

Today's Options[®] PFFS

A WellCare Company



2018 Evidence of Coverage

January 1 – December 31, 2018

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of *Today's Options Premier 300 (PFFS)*

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2018. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, *Today's Options Premier 300 (PFFS)*, is offered by *American Progressive Life & Health Insurance Company of New York, Inc.* (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means *American Progressive Life & Health Insurance Company of New York, Inc.* When it says “plan” or “our plan,” it means *Today's Options Premier 300 (PFFS)*.)

Today's Options[®] PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options[®] PFFS depends on contract renewal.

We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019.

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

Discrimination is Against the Law

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today's Options® PFFS, Today's Options® PPO, and Today's Options® HMO hereinafter, the Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Your Plan Name, P.O. Box 18200, Austin, TX 78760-8200, c/o Appeals and Grievances, 1-866-422-1690 (TTY users call 711), Fax: 1-800-817-3516, Email: AGMailbox@UniversalAmerican.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

English:

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711).

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-736-7442 (TTY: 711)。

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-736-7442 (телетайп: 711).

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-736-7442 (ATS: 711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-736-7442 (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-736-7442 (TTY: 711) 번으로 전화해 주십시오.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-736-7442 (رقم هاتف الصم والبكم: 711).

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-736-7442 (TTY: 711).

Yiddish:

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-888-736-7442 (TTY: 711).

Bengali:

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পিরষবা উপলব্ধ আছে। ফোন করুন 1-888-736-7442 (TTY: 711)।

Urdu:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1-888-736-7442 (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-736-7442 (TTY: 711).

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-736-7442 (TTY: 711).

Greek:

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-736-7442 (TTY: 711).

Albanian:

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-736-7442 (TTY: 711).

Hindi:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-736-7442 (TTY: 711) पर कॉल करें।

Table of Contents

2018 Evidence of Coverage
Table of Contents

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

Chapter 1.	Getting started as a member	3
	Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up-to-date.	
Chapter 2.	Important phone numbers and resources	13
	Tells you how to get in touch with our plan (<i>Today's Options Premier 300 (PFFS)</i>) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), and the Railroad Retirement Board.	
Chapter 3.	Using the plan's coverage for your medical services	23
	Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.	
Chapter 4.	Medical Benefits Chart (what is covered and what you pay)	35
	Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.	
Chapter 5.	Asking us to pay our share of a bill you have received for covered medical services	77
	Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.	
Chapter 6.	Your rights and responsibilities	82
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	

Table of Contents

Chapter 7.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	92
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
	<ul style="list-style-type: none"> • Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care you think is covered by our plan. This includes asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon. • Explains how to make complaints about quality of care, waiting times, customer service, and other concerns. 	
Chapter 8.	Ending your membership in the plan	130
	Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 9.	Legal notices	139
	Includes notices about governing law and about nondiscrimination.	
Chapter 10.	Definitions of important words	142
	Explains key terms used in this booklet	
Appendix A		
CONTACT TABLES.....		150
Appendix B		
<i>Today's Options Premier 300 (PFFS) Service and Premium Table.....</i>		154

CHAPTER 1

Getting started as a member

Chapter 1: Getting started as a member**Chapter 1. Getting started as a member**

SECTION 1	Introduction	5
Section 1.1	You are enrolled in <i>Today's Options Premier 300 (PFFS)</i> , which is a Medicare Private Fee-for-Service Plan	5
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	5
Section 1.3	Legal information about the <i>Evidence of Coverage</i>	5
SECTION 2	What makes you eligible to be a plan member?	6
Section 2.1	Your eligibility requirements	6
Section 2.2	What are Medicare Part A and Medicare Part B?	6
Section 2.3	Here is the plan service area for <i>Today's Options Premier 300 (PFFS)</i>	6
Section 2.4	U.S. Citizen or Lawful Presence	7
SECTION 3	What other materials will you get from us?	7
Section 3.1	Your plan membership card – Use it to get all covered care	7
Section 3.2	The <i>Provider Directory</i> : Your guide to all providers in the plan's network	8
SECTION 4	Your monthly premium for <i>Today's Options Premier 300 (PFFS)</i>	9
Section 4.1	How much is your plan premium?	9
SECTION 5	More information about your monthly premium	9
Section 5.1	Can we change your monthly plan premium during the year?	9
SECTION 6	Please keep your plan membership record up-to-date	10
Section 6.1	How to help make sure that we have accurate information about you	10
SECTION 7	We protect the privacy of your personal health information	11
Section 7.1	We make sure that your health information is protected	11
SECTION 8	How other insurance works with our plan	11
Section 8.1	Which plan pays first when you have other insurance?	11

SECTION 1 Introduction

Section 1.1	You are enrolled in <i>Today's Options Premier 300 (PFFS)</i>, which is a Medicare Private Fee-for-Service Plan
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You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, *Today's Options Premier 300 (PFFS)*.

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information on the individual requirement for MEC.

There are different types of Medicare health plans. *Today's Options Premier 300 (PFFS)* is a Medicare Advantage Private Fee-for-Service (PFFS) Plan. Like all Medicare health plans, this Medicare PFFS plan is approved by Medicare and run by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of *Today's Options Premier 300 (PFFS)*.

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

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

Section 1.3	Legal information about the <i>Evidence of Coverage</i>
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It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how *Today's Options Premier 300 (PFFS)* covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in *Today's Options Premier 300 (PFFS)* between January 1, 2018 and December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of *Today's Options Premier 300 (PFFS)* after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Chapter 1: Getting started as a member**Medicare must approve our plan each year**

Medicare (the Centers for Medicare & Medicaid Services) must approve *Today's Options Premier 300 (PFFS)* each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- – *and* – You live in our geographic service area (Section 2.3 below describes our service area).
- – *and* – you are a United States citizen or are lawfully present in the United States
- – *and* – You do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated.

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

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

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

Section 2.3 Here is the plan service area for *Today's Options Premier 300 (PFFS)*

Although Medicare is a Federal program, *Today's Options Premier 300 (PFFS)* is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described in Appendix B of this *Evidence of Coverage*.

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of state and into a state that is still within our service area, you must call Member Services in order to update your information. If you move into a state

Chapter 1: Getting started as a member

outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify *Today's Options Premier 300 (PFFS)* if you are not eligible to remain a member on this basis. *Today's Options Premier 300 (PFFS)* must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?**Section 3.1 Your plan membership card – Use it to get all covered care**

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

Today's Options® PFFS <small>A WellCare Company</small> Medicare Advantage Health Plans Today's Options Premier (PFFS) Health Plan ID (80840): <XXXX XXX XXX> Member ID: XXXXXXXXX Member: FIRST M LAST Copayments PCP SPEC ER UC MH/SA IP Medicare limiting charges apply. \$XX \$XX \$XX \$XX \$XX 2018 RX BIN XXXXXX RX PCN XXXXXXXX RX GRP XXXXXXXX		IMPORTANT PHONE NUMBERS: Member Services: 1-XXX-XXX-XXXX (TTY XXX) 24/7 Health Line: 1-XXX-XXX-XXXX (TTY XXX) Mental Health/Substance Abuse: 1-XXX-XXX-XXXX Provider Customer Service: 1-XXX-XXX-XXXX Pharmacy Provider Help Desk: 1-XXX-XXX-XXXX www.TodaysOptions.com Providers may send claims to: Medical: XXXXXXXXXXXX, P.O. Box XXXXX City, ST XXXXX-XXXX Pharmacy: XXXXXXXXXXXX, P.O. Box XXXXX City, ST XXXXX-XXXX Print Date: XX/XX/XXXX
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As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your *Today's Options Premier 300 (PFFS)* membership card while you are a plan member, you may have to pay the full cost yourself.

Chapter 1: Getting started as a member

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

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

The *Provider Directory* lists our network providers.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities we have signed contracts with to deliver certain covered services to members in our plan. These providers have already agreed to see members of our plan. See Chapter 3, Section 1.2 for information about the rules for getting your covered services under our plan.

We have network providers for all services covered under Original Medicare. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described in Chapter 3, Section 1.2.

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

There are several reasons why it is important for you to know whether our plan uses a network and if so, which providers are part of the plan's network:

- A network provider must furnish you care while an out-of-network provider has the right to refuse to treat you;
- A network provider will charge less cost-sharing than an out-of-network provider. The amount of cost-sharing you pay a provider who is not one of our network providers may be more than the cost-sharing you pay a network provider. In the plan's Medical Benefits Chart in Chapter 4 of this booklet, we indicate the services for which the cost-sharing amount differs between network providers and out-of-network providers.
- Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. Chapter 7 has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.
- In our plan's network, we must provide a sufficient number and range of providers to meet your needs.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can

Chapter 1: Getting started as a member

also see the *Provider Directory* at www.TodaysOptions.com, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for *Today's Options Premier 300 (PFFS)*

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for *Today's Options Premier 300 (PFFS)*. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

SECTION 5 More information about your monthly premium

Many members are required to pay other Medicare premiums

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

Your copy of *Medicare & You 2018* gives information about the Medicare premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 5.1 Can we change your monthly plan premium during the year?

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

SECTION 6 Please keep your plan membership record up-to-date

Section 6.1 How to help make sure that we have accurate information about you
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

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

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 8 in this chapter.)

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

SECTION 7 We protect the privacy of your personal health information

Section 7.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 8 How other insurance works with our plan

Section 8.1 Which plan pays first when you have other insurance?

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

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

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

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

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

Chapter 1: Getting started as a member

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2: Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1	<i>Today's Options Premier 300 (PFFS) contacts</i> (How to contact us, including how to reach Member Services at the plan) 15
SECTION 2	Medicare (How to get help and information directly from the Federal Medicare program) 18
SECTION 3	State Health Insurance Assistance Program (Free help, information, and answers to your questions about Medicare) 19
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare) 20
SECTION 5	Social Security 20
SECTION 6	Medicaid (A joint Federal and state program that helps with medical costs for some people with limited income and resources) 21
SECTION 7	How to contact the Railroad Retirement Board 22
SECTION 8	Do you have “group insurance” or other health insurance from an employer? 22

SECTION 1 *Today's Options Premier 300 (PFFS) contacts*
 (How to contact us, including how to reach Member Services at the plan)

How to contact our plan’s Member Services

For assistance with claims, billing or member card questions, please call or write to *Today's Options Premier 300 (PFFS)* Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(877) 907-2982
WRITE	Today's Options NPFSS P.O. Box 18100 Austin, TX 78760-8100
WEBSITE	www.TodaysOptions.com

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

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

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

Method	Coverage Decisions For Medical Care – Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m.

Chapter 2: Important phone numbers and resources

Method	Coverage Decisions For Medical Care – Contact Information
	seven days a week
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(877) 907-2982
WRITE	Today's Options NPFPS P.O. Box 18149 Austin, TX 78760-8149
WEBSITE	www.TodaysOptions.com

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

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

Method	Appeals For Medical Care – Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(800) 817-3516
WRITE	Today's Options NPFPS c/o Appeals and Grievances P.O. Box 18200 Austin, TX 78760-8200
WEBSITE	www.TodaysOptions.com

Chapter 2: Important phone numbers and resources**How to contact us when you are making a complaint about your medical care**

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

Method	Complaints About Medical Care – Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(800) 817-3516
WRITE	Today's Options NPFFS c/o Appeals and Grievances P.O. Box 18200 Austin, TX 78760-8200
MEDICARE WEBSITE	You can submit a complaint about <i>Today's Options Premier 300 (PFFS)</i> directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

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

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

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

Method	Payment Requests – Medical Care Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week

Chapter 2: Important phone numbers and resources

Method	Payment Requests – Medical Care Contact Information
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(713) 972-0247
WRITE	Today's Options NPPFS P.O. Box 18500 Austin, TX 78760-8500
WEBSITE	www.TodaysOptions.com

SECTION 2 Medicare

(How to get help and information directly from the Federal Medicare program)

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	https://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis

Chapter 2: Important phone numbers and resources

Method	Medicare – Contact Information
	<p>facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about <i>Today's Options Premier 300 (PFFS)</i>:</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about <i>Today's Options Premier 300 (PFFS)</i> directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program

(Free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. For information about the SHIP in your state, see Appendix A of this *Evidence of Coverage*.

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

State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about

Chapter 2: Important phone numbers and resources

your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

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

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta: (Quality Improvement Organization) – Contact Information
CALL	(866) 815-5440 8:00 a.m. to 5:00 p.m. Monday to Friday, 11:00 a.m. to 3:00 p.m. Saturday and Sunday
TTY	TTY: 1 (866) 868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEBSITE	www.bfccqioarea1.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already

Chapter 2: Important phone numbers and resources

getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid

(A joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. For information about the Medicaid office in your state, see Appendix A of this *Evidence of Coverage*.

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

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

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Medicaid.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	https://www.rrb.gov

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

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

CHAPTER 3

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

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

SECTION 1	Things to know about getting your medical care covered as a member of our plan	25
Section 1.1	What <i>are</i> “network providers” and “covered services”?	25
Section 1.2	Basic rules for getting your medical care covered by the plan	25
SECTION 2	Using providers in the plan's network to get your medical care	27
Section 2.1	How to get care from network providers	27
SECTION 3	How to get covered services when you have an emergency or urgent need for care or during a disaster	28
Section 3.1	Getting care if you have a medical emergency	28
Section 3.2	Getting care when you have an urgent need for services	29
Section 3.3	Getting care during a disaster	29
SECTION 4	What if you are billed directly for the full cost of your covered services?	30
Section 4.1	You can ask us to pay our share of the cost of covered services	30
Section 4.2	If services are not covered by our plan, you must pay the full cost	30
SECTION 5	How are your medical services covered when you are in a “clinical research study”?	31
Section 5.1	What is a “clinical research study”?	31
Section 5.2	When you participate in a clinical research study, who pays for what?	31
SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”	32
Section 6.1	What is a religious non-medical health care institution?	32
Section 6.2	What care from a religious non-medical health care institution is covered by our plan?	33
SECTION 7	Rules for ownership of durable medical equipment	33
Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?	33

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

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

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

Section 1.1 What are “network providers” and “covered services”?

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

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have signed contracts with us to deliver covered services to members in our plan. These providers have already agreed to see members of our plan. Section 1.2 describes the rules for getting covered services using our network providers.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, *Today's Options Premier 300 (PFFS)* must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Today's Options Premier 300 (PFFS) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider in the United States who (1) agrees to accept our plan's terms and conditions of payment prior to providing services to you and (2) is eligible to provide services under Original Medicare.**

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

- A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement (Medigap) plan. We have network providers (that is, providers who have signed contracts with our plan) for all services covered under Original Medicare. These providers have already agreed to see members of our plan. If your provider is not one of our network providers, then the provider is not required to accept the plan's terms and conditions of payment and they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider who will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on our website at: www.TodaysOptions.com.
- A provider is considered to have agreed to accept the terms and conditions of payment if the provider was aware that you are a member of *Today's Options Premier 300 (PFFS)* before providing services to you (for example: if you showed them your plan membership card); the provider had reasonable access to our terms and conditions of payment; and the provider provided covered services to you. The provider doesn't have to actually read the terms and conditions of payment – If the provider had the opportunity to read them and treats you, the law deems this provider to have agreed to accept our plan's terms and conditions of payment for that specific visit.
 - You must show your plan membership card every time you visit a provider. A provider can decide at every visit whether to accept our plan's terms and conditions, and thus treat you. A provider cannot change his/her mind about accepting the terms and conditions of payment after providing services.
 - Not all providers accept our plan's terms and conditions of payment or agree to treat you. A provider who decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. You may contact us at (866) 568-8921 for assistance locating another provider in your area who will accept our plan's terms and conditions of payment.
- If you need emergency care, it is covered whether a provider agrees to accept the plan's payment terms or not.
- Our plan has signed contracts with some providers to deliver covered services to members in our plan. These providers are our network providers. For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the cover of this booklet) or visit our website at www.TodaysOptions.com.

We have network providers for all services covered under Original Medicare. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan's terms and conditions of payment, as described earlier in this section.

The amount of cost-sharing you pay a provider who is not one of our network providers may be more than the cost-sharing you pay a network provider. In the plan's Medical Benefits Chart in Chapter 4 of this booklet, we indicate the services for which the cost-sharing amount differs between network providers and out-of-network providers.

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

- **You are required to pay only the copayment or coinsurance amount allowed by our plan at the time of the visit.** You should ask the provider to bill the plan for your covered services. If a provider asks you to pay the full amount of the services then send the bill or a copy of the bill to us to pay you back, remind the provider that you are only responsible for the cost-sharing amount. If the provider wants further information on payment for covered services, please have the provider contact us at (866) 568-8921 or via written correspondence to:

Today's Options NPFSS
P.O. Box 18500
Austin, TX 78760-8500

- Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan. Chapter 7 has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.
- *Today's Options Premier 300 (PFFS)* does not require members or their providers to obtain prior authorization or a referral from the plan as a condition for covering medically necessary services that are covered by our plan. Under prior authorization, a plan requires members or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for our members. If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it.

SECTION 2 Using providers in the plan's network to get your medical care

Section 2.1 How to get care from network providers

You may confirm that providers participate in the plan by calling Member Services at (866) 568-8921, by visiting our Website at www.TodaysOptions.com and researching the providers in the Provider Look-up Tool, or by verifying that the providers are listed in the Provider Directory. Member Services and the Provider Look-up Tool will have the most current information available. Once a network provider is located, you may contact the provider directly to access care. Because referrals are not required, you may seek the care of specialists without being treated by a Primary Care Physician first.

What if a network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your

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

provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

You may contact Member Services at (866) 568-8921, visit our website at www.TodaysOptions.com in the Provider Look-up Tool, or consult the Provider Directory for other network providers who may provide the same services.

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

Section 3.1 Getting care if you have a medical emergency

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

A “medical emergency” is when you believe that you have an injury or illness that requires immediate medical attention to prevent a disability or death. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval from our plan.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of the plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency

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

room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

This plan covers emergency services outside the U.S. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. If you decide to get follow-up care from the provider treating you, then you should advise them of your coverage as soon as possible, by showing them your plan membership card. The plan will pay for all medically-necessary plan-covered services furnished by the provider and non-emergency care that you get from any provider in the United States who agrees to accept our plan's terms and conditions of payment and is eligible to provide services under Original Medicare.

What if it wasn't a medical emergency?

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

Section 3.2 Getting care when you have an urgent need for services**What are “urgently needed services”?**

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

What providers should you use when you have an urgent need for care?

We cover urgently needed services you receive from a network provider or from any out-of-network provider who is willing to furnish services as a deemed provider.

To obtain information on accessing in-network urgently needed services contact Member Services or refer to the *Today's Options Premier 300 (PFFS)* website at www.TodaysOptions.com. The Member Services phone numbers are printed on the back cover of this booklet.

Section 3.3 Getting care during a disaster

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

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

Please visit the following website: <http://www.maine.gov/mema/> (Maine) or <http://www.dhses.ny.gov/oem/> (New York) for information on how to obtain needed care during a disaster.

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

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

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

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

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

Today's Options Premier 300 (PFFS) covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan.

Our plan will pay for all services that you receive from a network provider (including services you receive from an out-of-network provider when you are directed to see that provider by the plan or a network provider). If you decide to see an out-of-network provider who accepts our plan's terms and conditions of payment on your own, you and the provider have the right to request a written coverage decision from us before you get the service in order to confirm that the service is medically necessary and a covered service, and therefore, will be paid for by our plan.

If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

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

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once you have reached your benefit limit, the amount you pay towards that benefit will not count towards your out-of-pocket maximum. For example, you may have to pay the full cost of any skilled nursing facility care you get after our Plan's payments reach the benefit limit of 100 day stay per benefit period. You can

call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a “clinical research study”?

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

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

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

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

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

- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<https://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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

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

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

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

Coverage for your stay in the religious non-medical care institution would follow the coverage descriptions in the Benefits Chart in Chapter 4, section 2.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of *Today's Options Premier 300 (PFFS)*, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances

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

we will transfer ownership of the DME item to you. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

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

CHAPTER 4

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

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

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

SECTION 1	Understanding your out-of-pocket costs for covered services	37
Section 1.1	Types of out-of-pocket costs you may pay for your covered services	37
Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?	37
Section 1.3	How does “balance billing” affect your costs?	38
SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered for you and how much you will pay	38
Section 2.1	Your medical benefits and costs as a member of the plan	38
SECTION 3	What services are not covered by the plan?	73
Section 3.1	Services we do <i>not</i> cover (exclusions)	73

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of *Today's Options Premier 300 (PFFS)*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)
- **“Balance billing”** is when providers, such as doctors or hospitals, charge and bill patients up to 15% more than the plan’s payment amount for services. The “balance billing” amount is collected in addition to the patient’s regular plan cost-sharing amount. *Today's Options Premier 300 (PFFS)* does not allow providers who provide plan-covered services to balance bill members of our plan. (For more information, see Section 1.3 of this chapter.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of *Today's Options Premier 300 (PFFS)*, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2018 is \$6,700.00. The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked in the Medical Benefits Chart as **“not generally covered by Medicare”**. If you reach the maximum out-of-pocket amount of \$6,700.00, you will not have to pay any

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

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

Section 1.3 How does “balance billing” affect your costs?

Our plan does not allow “balance billing.” This means a provider is allowed to collect only the plan cost-sharing amounts from you and is not allowed to charge or bill you more for services. Balance billing is prohibited by providers who provide plan-covered services to *Today's Options Premier 300 (PFFS)* members.

There is an additional type of balance billing that physicians who do not participate with Medicare and who are not in the plan’s network have a right to collect. However, you will never have to pay this type of balance billing. The provider will collect this balance billing amount from us and you will only pay your cost-sharing amount. If you have any questions about how much you would have to pay a provider, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay**Section 2.1 Your medical benefits and costs as a member of the plan**

The Medical Benefits Chart on the following pages lists the services *Today's Options Premier 300 (PFFS)* covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are provided to our members.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018 Handbook*. View it online at <https://www.medicare.gov> or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)


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

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Generally, in order for a service to be considered Preventative and have the \$0 cost share applied, certain criteria as defined by Medicare must be met. Please contact Member Service for more information. Additionally, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a cost share will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.





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



Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered screening ultrasound for abdominal aortic aneurysm preventive screenings.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. 	<p>In-Network</p> <p>\$300.00 copay for Medicare-covered ambulance services per one-way trip.</p> <p>Out-of-Network</p> <p>\$300.00 copay for Medicare-covered ambulance services per one-way trip.</p> <p>This cost share is not waived if you are admitted for inpatient hospital care.</p>



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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. 	
 <p>Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <p>Out-of-Network</p> <p>30% of the cost for this preventative service.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
 <p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered bone mass measurement.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>


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

Services that are covered for you	What you must pay when you get these services
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>\$0.00 copay for Medicare-covered breast exams.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered mammography screening.</p> <p>30% of the cost for Medicare-covered breast exams.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>In-Network</p> <p>\$35.00 copay for Medicare-covered Cardiac Rehabilitation Services.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered Cardiac Rehabilitation Services.</p> <p>Cardiac Rehabilitation Services will take the Cardiac Rehabilitation Cost share, regardless of the specialty of the provider.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered intensive therapy to reduce the risk of cardiovascular disease.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or</p>




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

Services that are covered for you	What you must pay when you get these services
	surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.
 <p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).</p> <p>The Medicare-covered blood tests include:</p> <ul style="list-style-type: none"> • Total cholesterol test • Cholesterol test for high density lipoproteins • Triglycerides test 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered cardiovascular screening blood test.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
 <p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered pap smears and pelvic exams.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only Manual manipulation of the spine to correct subluxation 	<p>In-Network</p> <p>\$20.00 copay for each Medicare-covered service.</p> <p>Out-of-Network</p>

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

Services that are covered for you	What you must pay when you get these services
	<p>30% of the cost for each Medicare-covered service.</p> <p>The Chiropractic Services cost share will apply to Medicare Covered Chiropractic services provided by a Chiropractor, PCP or other specialist, as appropriate.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy • For Diagnostic colonoscopy, see the Outpatient diagnostic tests and therapeutic services and supplies section in the Medical Benefits Chart. 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered colorectal screenings.</p> <p>A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient Surgery cost sharing described later in this benefit grid.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

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

Services that are covered for you	What you must pay when you get these services
 <p>Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered screening.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
 <p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered Diabetes screenings.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
 <p>Diabetes self-management training, diabetic services and supplies</p> <p>These services and supplies are covered for members who meet certain conditions with a doctor's order.</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p>	<p>In-Network</p> <p>\$0.00 copay for Medicare-covered Diabetes self-management training.</p> <p>20% of the cost for Medicare-covered Therapeutic shoes or inserts.</p> <p>\$0.00 copay for preferred brand Medicare-covered Diabetes monitoring supplies.</p> <p>20% of the cost for non-preferred brand Medicare-covered Diabetes monitoring supplies.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions 	<p>Plan maintains a list of preferred brand diabetic monitoring supplies that are subject to lower cost-sharing.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered Diabetes self-management training.</p> <p>30% of the cost for Medicare-covered Therapeutic shoes or inserts.</p> <p>30% of the cost for Medicare-covered Diabetes monitoring supplies.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>To qualify for Medicare coverage of durable medical equipment, Medicare has specific criteria for coverage that must be met.</p> <p>(For a definition of “durable medical equipment,” see Chapter 10 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p>	<p>In-Network</p> <p>20% of the cost for Medicare-covered durable medical equipment.</p> <p>20% of the cost for Medicare-covered medical supplies.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered durable medical equipment.</p> <p>30% of the cost for Medicare-covered medical supplies.</p> <p>For both in and out of network benefits, in addition, physician services and doctor office visit cost-share (primary care or specialty care as applicable), urgently needed care, or home health care cost-share also applies.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p>	<p>In-Network and Out-of-Network</p> <p>\$80.00 copay for each Medicare-covered emergency room visit.</p> <p>If you are admitted to the hospital for inpatient hospital care within 24 hours for the same condition, the copayment is waived for the emergency room visit.</p> <p>If you have surgery as an outpatient within 24 hours for the same condition, the copayment is waived for the emergency room visit and the applicable outpatient surgical cost share applies.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p> <p>Currently, Medicare and Medicare Advantage programs do not recognize Free Standing Emergency Rooms, which are distinct and separate from hospitals, as providers qualified to furnish emergency services. Services received at freestanding ERs will not be covered by <i>Today's Options Premier 300 (PFFS)</i> and will be the financial responsibility of the member.</p>
<p>Worldwide Emergency Coverage</p> <p>This plan offers Worldwide coverage for Emergency Care, not generally covered by Medicare. This benefit includes emergency care as described above in this benefit chart until you are medically stabilized for transport or discharge up to a maximum of \$20,000 or</p>	<p>Outside the United States – Worldwide Emergency Coverage:</p> <p>20% of the cost for emergency services outside of the U.S.</p> <p>Coinsurance is not waived for Worldwide Coverage if you are admitted to the hospital.</p> <p>Cost shares paid for Worldwide Emergency Coverage does not apply to your Maximum Out-Of-Pocket Limits.</p>

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

Services that are covered for you	What you must pay when you get these services
60 days per calendar year. It does not include worldwide coverage for Urgent Care.	
 Health and wellness education programs <p>These are care management programs that include assistance for such health conditions as high blood pressure, cholesterol, respiratory illness, diabetes and others. The benefit includes:</p> <ul style="list-style-type: none"> • Annual Physical Exam • Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) • Enhanced Disease Management <p>An Annual Physical Exam includes examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck and extremities) and detailed medical/family history, in addition to services included in the Annual Wellness Visit.</p>	<p>In-Network</p> <p>\$0.00 copay for Nursing Hotline benefit.</p> <p>\$0.00 copay for Enhanced Disease Management benefit.</p> <p>\$0.00 copay for an annual physical exam.</p> <p>Out-of-Network</p> <p>30% of the cost for Nursing Hotline benefit.</p> <p>30% of the cost for Enhanced Disease Management benefit.</p> <p>\$15.00 copay for an annual physical exam.</p> <p>For both in and out of network benefits, if your physician performs diagnostic or surgical procedures or if other medical services are provided as a result of Health and Wellness education programs, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>In addition, our plan includes the additional benefit of one (1) annual hearing exam not generally covered by Medicare.</p>	<p>In-Network</p> <p>\$20.00 copay for annual hearing exams.</p> <p>\$5.00 copay for each Medicare-covered basic hearing and balance exam performed by a primary care doctor.</p> <p>\$20.00 copay for each Medicare-covered basic hearing and balance exam performed by a specialist, audiologist or other provider that is not a primary care doctor.</p> <p>Out-of-Network</p> <p>30% of the cost for annual hearing exam.</p>


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

Services that are covered for you	What you must pay when you get these services
	<p>\$15.00 copay for each Medicare-covered basic hearing and balance exam performed by a primary care doctor.</p> <p>30% of the cost for each Medicare-covered basic hearing and balance exam performed by a specialist, audiologist or other provider that is not a primary care doctor.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered HIV screenings.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Home health agency care</p> <p>Medicare's coverage of Home Health services depends upon the Medicare specific criteria for coverage being met.</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p>	<p>In-Network</p> <p>\$0.00 copay for each Medicare-covered home health visit.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered home health visit.</p> <p>For both in and out of network benefits, there will also be a copayment and /or coinsurance for medically necessary Medicare-Covered Services for Durable Medical Equipment, prosthetic</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>devices, certain medical supplies and Medicare Part B Prescription Drugs, where applicable.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not <i>Today's Options Premier 300 (PFFS)</i>.</p> <p>The cost-share for hospice consultation services is the same as the cost-share you pay for physician services, including doctor office visits (see benefit category below).</p>

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

Services that are covered for you	What you must pay when you get these services
<p>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan’s network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for deemed providers. <p>For services that are covered by <i>Today's Options Premier 300 (PFFS)</i> but are not covered by Medicare Part A or B: <i>Today's Options Premier 300 (PFFS)</i> will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.</p>	
 <p>Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered Flu, Hepatitis, Pneumonia, and other Medicare-covered vaccines/immunizations and their administration.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>Out-of-Network</p> <p>30% of the cost for Medicare-covered Flu, Hepatitis, Pneumonia, and other Medicare-covered vaccines/immunizations and their administration.</p> <p>A vaccine and/or immunization must be considered a Part B drug by Medicare in order to be covered under this benefit. Some vaccinations and their administration, such as the Shingles vaccination, are considered Part D Drugs and are not covered under this benefit.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>There is no limit to the number of medically necessary days covered by the plan each admission. There is no limit to the number of medically necessary days covered by the plan each Benefit Period.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services 	<p>In-Network</p> <p>For each Medicare-covered hospital stay: Days 1 - 6: \$260.00 copay per day Days 7 - 90: \$0.00 copay per day.</p> <p>Out-of-Network</p> <p>For each Medicare-covered hospital stay: Days 1 - 7: \$300.00 copay per day Days 8 - 90: \$0.00 copay per day.</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing that you would pay at a network hospital.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you may be moved to a network hospital in order to</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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. 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 <i>Today's Options Premier 300 (PFFS)</i> provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion (or two companions if you are a minor). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. 	<p>pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p> <p>Inpatient stays at a Long Term Acute Care Facility are covered according to the Long Term Acute Care benefit section in this chapter.</p> <p>Medicare hospital benefit periods do not apply. For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility (such as Acute Inpatient Rehabilitation Hospital or to another Acute care Hospital) is considered a new admission.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Inpatient mental health care</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. You receive up to 190-days in a psychiatric hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. 	<p>In-Network</p> <p>For each Medicare-covered hospital stay: Days 1 - 6: \$260.00 copay per day Days 7 - 190: \$0.00 copay per day.</p> <p>Out-of-Network</p> <p>For each Medicare-covered hospital stay: Days 1 - 7: \$300.00 copay per day Days 8 - 190: \$0.00 copay per day.</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p>
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in</p>	<p>Your applicable outpatient services copayments and/or coinsurances apply to the Medicare-Covered Services and supplies you receive during a non-covered inpatient hospital, LTAC or SNF stay.</p> <p>Please see outpatient services section below for your costs.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>the hospital or the skilled nursing facility (SNF). Covered services include:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	
<p>Long term acute care (LTAC)</p> <p>Coverage includes inpatient hospital care provided in a Long Term Acute Care (LTAC) facility, including room, board, related services and supplies.</p> <p>LTAC is only a covered benefit when in-network.</p> <p>Care is limited to 90 days of Medically Necessary LTAC related hospitalization for each Benefit Period to include Medically</p>	<p>Long Term Acute Care (LTAC) is only a covered benefit when in-network. The LTAC coverage will be as follows, in-network:</p> <p>\$260.00 copayment per day, days 1 thru 6 and \$0.00 copayment per day, days 7 thru 60 per LTAC admit for the first 60 days. This co-payment is waived if the LTAC confinement is a transfer from an inpatient acute care setting. 90 days of Medically Necessary LTAC related hospitalization for each Benefit Period to include Medically Necessary inpatient hospital acute</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Necessary inpatient hospital acute care days, and up to 60 lifetime reserve days to a maximum of 150 days.</p> <p>A benefit period starts when you enter a hospital, LTAC or SNF facility, and ends when you have not received inpatient, LTAC or Medicare Covered SNF care for 60 days in a row. If you go into a LTAC facility after the benefit period has ended, a new one will begin.</p>	<p>care days, the Benefit Period as defined by Medicare Part A, and up to 60 lifetime reserve days to a maximum of 150 days.</p> <p>\$283 per day copayment for days 61-90 per Benefit Period;</p> <p>\$566 each lifetime reserve day.</p> <p>If the LTAC admit is a transfer from an inpatient acute admit, the inpatient acute cost share applies for the first 60 days of the combined acute and LTAC admits, and the additional LTAC cost shares won't be applied until day 61 of the combined admits.</p> <p>Cost shares are applied starting on the first day of admission and do not include the date of discharge.</p> <p>*Cost shares listed represent the 2016 rates for the Medicare Benefit periods.</p>
<p> Medical nutrition therapy</p> <p>Medicare-Covered Medical Nutritional Therapy is a benefit for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover:</p> <ul style="list-style-type: none"> • 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), • 2 hours each year after that <p>If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered medical nutritional therapy.</p> <p>\$0.00 copay for supplemental medical nutritional therapy.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered medical nutritional therapy.</p> <p>30% of the cost for supplemental medical nutritional therapy.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Our plan also covers the following services as a supplemental benefit, not generally covered by Medicare:</p> <ul style="list-style-type: none"> • 1 additional hour of one-on-one counseling services per benefit year for members with diabetes or renal disease, or after a kidney transplant • 3 hours of one-on-one counseling services per benefit year for members with medical necessity, including but not limited to obesity and related comorbidities, as determined by the plan 	
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered MDPP benefit.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services 	<p>In-Network</p> <p>20% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare).</p> <p>20% of the cost for Part B-covered chemotherapy drugs.</p> <p>Out-of-Network</p> <p>30% of the cost for Part B-covered Drugs covered under Medicare Part B (Original Medicare).</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens and Allergy shots • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	<p>30% of the cost for Part B-covered chemotherapy drugs.</p> <p>For both in and out of network benefits, coinsurance for Medicare Part B prescription drugs applies in addition to the cost-share for home health, outpatient and physician services including but not limited to allergy testing, preventative care and additional benefits as described in this Benefit Chart.</p> <p>For Medicare Part B prescription drugs obtained at a Network Pharmacy the coinsurance is applied to the health plan's actual cost, which reflects the Pharmacy Benefit Manager's pricing and dispensing fee, both the pricing and dispensing fee vary by drug and by brand vs. generic. It can also vary by the type of dispensing pharmacy (e.g. long term care vs. retail).</p> <p>For Medicare Part B prescription drugs obtained from a physician, the coinsurance is applied to the plan's allowable charge.</p>
 <p>Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered behavioral counseling to promote sustained weight loss.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the</p>

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

Services that are covered for you	What you must pay when you get these services
	same visit, then the appropriate cost-share applies for those services rendered during that visit.
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Chemotherapy services – see Medicare Part B prescription drugs in this Benefit Chart for the cost share for Medicare-covered Part B chemotherapy drugs • Cardiac stress tests • MRIs and CT Scans • PET Scans • Intensity modulated therapeutic treatment • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests • Diagnostic Colonoscopy 	<p>In-Network</p> <p>\$0.00 copay for Medicare-covered lab services.</p> <p>\$0.00 copay for Medicare-covered non-radiologic diagnostic procedures and tests.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays).</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p> <p>\$15.00 copay for Medicare-covered X-rays.</p> <p>\$0.00 copay for Medicare-covered Blood Services.</p> <p>20% of the cost for Medicare-covered medical supplies.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered lab services.</p> <p>30% of the cost for Medicare-covered non-radiologic diagnostic procedures and tests.</p> <p>30% of the cost for Medicare-covered diagnostic radiology services (not including X-rays).</p> <p>30% of the cost for Medicare-covered therapeutic radiology services.</p> <p>30% of the cost for Medicare-covered X-rays.</p> <p>30% of the cost for Medicare-covered Blood Services.</p> <p>30% of the cost for Medicare-covered medical supplies.</p> <p>For both in and out of network benefits, a separate facility charge could apply for the facility in which the service is received.</p> <p>For both in and out of network benefits, in addition, DME/medical supplies, Medicare Part</p>

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

Services that are covered for you	What you must pay when you get these services
	B Drugs, physician services and doctors office visit cost-share also applies.
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself • Services performed in an outpatient clinic • Services performed at an outpatient hospital, including same day surgery 	<p>The cost shares for these services are provided in the appropriate section of this Benefit Chart.</p> <p>Please refer to Emergency Care</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Outpatient Mental Health Care</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Please refer to Medicare Part B Prescription Drugs</p> <p>Please refer to Medically Necessary Medical or Surgical Services in a Physician's Office</p> <p>Please refer to Outpatient Surgery, Including Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</p>
<p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are</p>	

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

Services that are covered for you	What you must pay when you get these services
<p>not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>In-Network</p> <p>\$40.00 copay for each Medicare-covered individual therapy visit provided by a non-physician.</p> <p>\$40.00 copay for each Medicare-covered group therapy visit provided by a non-physician.</p> <p>\$40.00 copay for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>\$40.00 copay for each Medicare-covered group therapy visit with a psychiatrist.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered individual therapy visit provided by a non-physician.</p> <p>30% of the cost for each Medicare-covered group therapy visit provided by a non-physician.</p> <p>30% of the cost for each Medicare-covered individual therapy visit with a psychiatrist.</p> <p>30% of the cost for each Medicare-covered group therapy visit with a psychiatrist.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Outpatient observation</p> <p>Observation care includes ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.</p> <p>Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff by-laws to admit patients to the hospital or to order outpatient tests.</p>	<p>In-Network and Out-of-Network</p> <p>There is no cost-share for Medicare-covered Outpatient Observation.</p> <p>Additional costs will apply for Medicare Part B prescription drugs.</p> <p>If you are admitted to observation from outpatient surgery or an ambulatory surgery center, you pay the applicable copayment for outpatient surgery services or ambulatory surgical services and the coinsurance for Medicare Part B prescription drugs.</p> <p>If you are admitted to an inpatient acute level of care (as described in Inpatient Hospital care) from outpatient surgery, ambulatory surgery or observation, this copayment and coinsurance and the coinsurance for Medicare Part B prescription drugs are waived and the Inpatient Hospital care copayment applies.</p> <p>If you are admitted to outpatient hospital observation from the emergency room (up to 48 hours in the emergency room), the emergency room copayment applies and the coinsurance for Medicare Part B prescription drugs applies. If you are then admitted to the inpatient acute level of care (as described in inpatient hospital care) within 48 hours, the emergency room copayment and the coinsurance for Medicare Part B prescription drugs are waived and the Inpatient hospital care copayment applies.</p> <p>If you are admitted to outpatient hospital observation from the emergency room (up to 48 hours in the emergency room), and then undergo surgery as an outpatient, the emergency room copayment is waived and the outpatient surgery cost share and the coinsurance for Medicare Part B prescription drugs will apply.</p>
<p>Outpatient rehabilitation services</p>	<p>In-Network</p> <p>\$35.00 copay for each Medicare-covered Physical and/or Speech and Language Therapy visit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$35.00 copay for each Medicare-covered Occupational Therapy visit.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered Physical and/or Speech and Language Therapy visit.</p> <p>30% of the cost for each Medicare-covered Occupational Therapy visit.</p> <p>For both in and out of network benefits, if these services are provided in your home, then the home health cost-share applies instead of the above.</p> <p>Outpatient Rehabilitation Services will take the Outpatient Rehabilitation Cost share, regardless of the specialty of the provider.</p> <p>There will also be a copayment and/or coinsurance for Medically Necessary Medicare-Covered Services for Durable Medical Equipment, prosthetic devices, certain medical supplies and Medicare Part B prescription drugs, where applicable.</p>
<p>Outpatient substance abuse services</p> <p>Non-residential ambulatory services provided for the treatment of drug or alcohol dependence, without the use of pharmacotherapies. Services may include intensive outpatient services as well as traditional counseling.</p>	<p>In-Network</p> <p>\$40.00 copay for Medicare-covered individual therapy visits.</p> <p>\$40.00 copay for Medicare-covered group therapy visits.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered individual therapy visits.</p> <p>30% of the cost for Medicare-covered group therapy visits.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p>	<p>In-Network</p> <p>\$250.00 copay for each Medicare-covered outpatient hospital facility visit.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>\$200.00 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered outpatient hospital facility visit.</p> <p>30% of the cost for each Medicare-covered ambulatory surgical center visit.</p> <p>For both In and Out-of-Network:</p> <p>Additional coinsurance applies for Medicare-covered Part B prescription drugs.</p> <p>Services include surgical services, minor surgical services, heart cath, oncology related services, wound care services, infusion therapies, respiratory services and other therapeutic procedures done in an outpatient facility setting.</p> <p>If you are admitted to the inpatient acute level of care from outpatient surgery or ambulatory surgery the above cost share is waived and the Inpatient Hospital care cost share applies.</p> <p>If you are admitted to observation from outpatient surgery or an ambulatory surgical center, you pay the applicable copayment for outpatient surgery services or ambulatory surgical services and the coinsurance for the Medicare Part B prescription.</p> <p>If you receive services at a physician's office but they are owned by a hospital and considered to be an outpatient department of the hospital, the outpatient Surgery cost share will apply.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more</p>	<p>In-Network</p> <p>\$55.00 copay per day for Medicare-covered partial hospitalization program services.</p> <p>Out-of-Network</p>


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

Services that are covered for you	What you must pay when you get these services
intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	30% of the cost for Medicare-covered partial hospitalization program services.
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p>In-Network</p> <p>\$5.00 copay for each Medicare-covered primary care doctor visit.</p> <p>\$30.00 copay for each Medicare-covered specialist visit.</p> <p>Out-of-Network</p> <p>\$15.00 copay for each Medicare-covered primary care doctor visit.</p> <p>\$50.00 copay for each Medicare-covered specialist visit.</p> <p>For both in and out of network benefits, in addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered Services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, eyeglasses and contacts after cataract surgery and Medicare Part B prescription drugs, as described in this Benefit Chart.</p> <p>If your physician's practice is owned by a hospital system, they may be considered to be an outpatient department of the hospital, and cost shares for their services may fall under the "Outpatient Surgery and Services performed at an Outpatient Hospital or Ambulatory Surgery Center" benefit sections. Please see that section for applicable cost shares.</p> <p>For other physician services not listed here, please see the appropriate section of this Benefit Chart for details.</p> <p>Medicare Covered Chiropractic services provided by a PCP or specialist, when applicable, are</p>

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

Services that are covered for you	What you must pay when you get these services
	<p>covered under the Chiropractic Benefit and will take the Chiropractic Cost Share.</p> <p>Medicare Covered Outpatient Rehabilitation services provided by a PCP or specialist, when applicable, are covered under the Outpatient Rehabilitation Benefit and will take the Outpatient Rehabilitation Cost share.</p> <p>Medicare Covered Cardiac/Pulmonary Rehabilitation services provided by a PCP or specialist, when applicable, are covered under the Cardiac/Pulmonary Rehabilitation Benefit and will take the Cardiac/Pulmonary Rehabilitation Cost share.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>In-Network</p> <p>\$45.00 copay for each Medicare-covered visit.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered visit.</p> <p>For both in and out of network benefits, in addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, and Medicare Part B prescription drugs, as described in this Benefit Chart.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered prostate cancer screening exams.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the</p>


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

Services that are covered for you	What you must pay when you get these services
	same visit, then the appropriate cost-share applies for those services rendered during that visit.
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>In-Network</p> <p>20% of the cost for each Medicare-covered prosthetic or orthotic device or supply, including replacement or repairs of such devices and supplies, which includes parenteral /enteral nutrition.</p> <p>Out-of-Network</p> <p>30% of the cost for each Medicare-covered prosthetic or orthotic device or supply, including replacement or repairs of such devices and supplies, which includes parenteral /enteral nutrition.</p> <p>For both in and out of network benefits, in addition, physician services and doctor office visit cost-share (primary care or specialty care as applicable), urgently needed care, or home health care cost-share also applies.</p>
<p>Pulmonary rehabilitation services</p> <p>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.</p>	<p>In-Network</p> <p>\$30.00 copay for Medicare-covered Pulmonary Rehabilitation Services.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered Pulmonary Rehabilitation Services.</p> <p>Pulmonary Rehabilitation Services will take the Pulmonary Rehabilitation Cost share, regardless of the specialty of the provider.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> <p>Out-of-Network</p>

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

Services that are covered for you	What you must pay when you get these services
<p>If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>30% of the cost for Medicare-covered screening and counseling to reduce alcohol misuse.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered counseling and shared decision making visit or for the LDCT.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>


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

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered screening for sexually transmitted infections (STIs) and counseling to prevent STIs.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) 	<p>In-Network</p> <p>\$0.00 copay for Medicare-covered kidney disease education services.</p> <p>20% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered kidney disease education services.</p> <p>30% of the cost for Medicare-covered outpatient renal dialysis treatments and dialysis treatments in a home setting.</p> <p>For both in and out of network benefits, Staff-assisted home dialysis using nurses to assist ESRD beneficiaries is not included in the ESRD PPS and is not a Medicare covered service. See</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) • Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.” 	<p>"Inpatient Hospital Care" for cost shares applicable to inpatient dialysis treatments.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Up to 100 days per Benefit Period of confinement and skilled care services in SNF or alternate setting are Covered Services when such services meet the Plan’s and Medicare coverage guidelines. Medicare’s requirement that a patient spend at least three (3) consecutive days in a hospital for a related condition before transferring to a SNF is not required. The 100-day per Benefit Period includes SNF days received through the Plan, Original Medicare or any other Medicare Advantage Organization during the Benefit Period.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) 	<p>In-Network</p> <p>Days 1 - 20: \$0.00 copay per day Days 21 - 100: \$165.00 copay per day.</p> <p>Out-of-Network</p> <p>Days 1 - 20: \$0.00 copay per day Days 21 - 100: \$250.00 copay per day.</p> <p>A benefit period begins on the first day you go into a facility (acute inpatient, long term acute or skilled nursing facility (SNF)). The benefit period ends when you haven’t received any care in an acute inpatient, long term acute care facility (LTAC) or skilled nursing facility (SNF) for 60 consecutive days. If you go to the SNF after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. You are an inpatient in a SNF only if your care in a SNF meets certain standards for skilled level of care. Specifically, in order to be inpatient in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services 	
 <p>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>Out-of-Network</p> <p>30% of the cost for Medicare-covered smoking cessation counseling services.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the</p>

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

Services that are covered for you	What you must pay when you get these services
<p>cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Our plan does not cover urgently needed care or any other non-emergency care if you receive the care outside of the United States.</p>	<p>In-Network and Out-of-Network</p> <p>\$35.00 copay for each visit to an Urgent Care Center that accepts Medicare.</p> <p>For both in and out of network benefits, in addition to the cost-share above, there will be a copay and/or coinsurance for Medically Necessary Medicare-Covered services for Durable Medical Equipment and supplies, prosthetic devices and supplies, outpatient diagnostic tests and therapeutic services, and Medicare Part B prescription drugs, as described in this Benefit Chart.</p> <p>If you are admitted to the inpatient acute level of care from an Urgent Care Center, the above cost shares are waived and the Inpatient Hospital care cost shares applies.</p> <p>Urgently needed care may be received from both contracted and non-contracted urgent care centers, as long as the urgent care center accepts Medicare. Services received from an urgent care center that does not accept Medicare will be the financial responsibility of the member.</p>
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. 	<p>In-Network</p> <p>\$0.00 copay for Medicare-covered vision exams.</p> <p>\$0.00 copay for annual routine vision exam (refractions).</p> <p>\$0.00 copay for Medicare-covered Glaucoma screening.</p> <p>\$20.00 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Out-of-Network</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) <p>Our plan also includes the following benefit, not generally covered by Medicare:</p> <ul style="list-style-type: none"> • One (1) annual routine vision exam (refraction) <p>Note: An Ophthalmologist or an Optometrist must prescribe these items:</p> <ul style="list-style-type: none"> • Corrective lenses • Prosthetic lenses • Cataract glasses • Conventional glasses and contact lenses after surgery with an intraocular lens • Intraocular lens 	<p>30% of the cost for Medicare-covered vision exams.</p> <p>30% of the cost for annual routine vision exam (refractions).</p> <p>30% of the cost for Medicare-covered Glaucoma screening.</p> <p>30% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Medicare-Covered Benefits is limited to office visits and non-radiologic vision testing.</p> <p>For both in and out of network benefits, facility and/or specialist cost share will apply to other services performed, including surgical services.</p> <p>In addition to the cost-shares above, there will be a copay and /or coinsurance for outpatient diagnostic tests and therapeutic services and Medicare Part B prescription drugs, as described in this Benefit Chart. For other physician services not listed here, please see the appropriate section of this Benefit Chart for details.</p> <p>Fittings for eyeglasses and contacts are covered under the eyewear benefit and subject to the same diagnosis restrictions.</p> <p>Laser Cataract Surgery and Laser Vision Surgery are not covered services.</p>
 <p>“Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education</p>	<p>In-Network</p> <p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p> <p>Out-of-Network</p>

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

Services that are covered for you	What you must pay when you get these services
<p>and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>30% of the cost for this preventative service.</p> <p>For both in and out of network benefits, if your physician performs additional diagnostic or surgical procedures or if other medical services are provided for other medical conditions, in the same visit, then the appropriate cost-share applies for those services rendered during that visit.</p>

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

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

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

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

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

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		(See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Non-routine dental care.		✓

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		<p style="text-align: center;">✓</p> Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		<p style="text-align: center;">✓</p> Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals	✓	
Orthopedic shoes		<p style="text-align: center;">✓</p> If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		<p style="text-align: center;">✓</p> Orthopedic or therapeutic shoes for people with diabetic foot disease.
Hearing aids, or exams to fit hearing aids.	✓	
Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		<p style="text-align: center;">✓</p> Eyeglasses are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Routine Transportation	✓	

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

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

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

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

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services 79

Section 1.1 If you pay our plan’s share of the cost of your covered services, or if you receive a bill, you can ask us for payment 79

SECTION 2 How to ask us to pay you back or to pay a bill you have received 80

Section 2.1 How and where to send us your request for payment 80

SECTION 3 We will consider your request for payment and say yes or no 81

Section 3.1 We check to see whether we should cover the service and how much we owe 81

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal 81

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

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

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

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

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

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

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

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

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

- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

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

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

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.TodaysOptions.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

For Medical Care:
Today's Options NPFPS
P.O. Box 18500
Austin, TX 78760-8500

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, Where to send a request that asks us to pay for our share of the cost for medical care you have received.

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

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

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 7.

CHAPTER 6

Your rights and responsibilities

Chapter 6: Your rights and responsibilities**Chapter 6. Your rights and responsibilities**

SECTION 1	Our plan must honor your rights as a member of the plan	84
Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)	84
Section 1.2	We must treat you with fairness and respect at all times	84
Section 1.3	We must ensure that you get timely access to your covered services	84
Section 1.4	We must protect the privacy of your personal health information	85
Section 1.5	We must give you information about the plan, its network of providers, and your covered services	86
Section 1.6	We must support your right to make decisions about your care	87
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made	88
Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?	89
Section 1.9	How to get more information about your rights	89
SECTION 2	You have some responsibilities as a member of the plan	90
Section 2.1	What are your responsibilities?	90

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact Civil Rights Coordinator, *Today's Options Premier 300 (PFFS)*, P.O. Box 18200, Austin, Texas 78760-8200, c/o Appeals and Grievances, 1-866-422-1690 (TTY users call 711), Fax: 1-800-817-3516, Email: AGMailbox@UniversalAmerican.com

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with (866) 568-8921. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact Information is included in this Evidence of Coverage or with this mailing, or you may contact (866) 568-8921 for additional information.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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

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

Section 1.3 We must ensure that you get timely access to your covered services

You may seek care from any provider in the United States, if the provider agrees to accept our plan's terms and conditions of payment prior to providing services to you and is eligible to provide services under Original Medicare, as described in Chapter 3, Section 1.2. You should always (except possibly in emergencies) show the provider your PFFS plan membership card. As a plan member,

Chapter 6: Your rights and responsibilities

you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*.

Our plan has signed contracts with some providers to deliver covered services to members in our plan. These providers are our network providers. Chapter 3, Section 1.2 describes the rules for getting covered services using our network providers.

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

Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

Chapter 6: Your rights and responsibilities

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of *Today's Options Premier 300 (PFFS)*, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

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

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

Chapter 6: Your rights and responsibilities

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

Section 1.6 We must support your right to make decisions about your care**You have the right to know your treatment options and participate in decisions about your health care**

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

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

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

Chapter 6: Your rights and responsibilities

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Department of Health. *Please refer to Appendix A at the end of the Evidence of Coverage for contact information.*

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Chapter 6: Your rights and responsibilities

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

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?**If it is about discrimination, call the Office for Civil Rights**

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact the **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Chapter 6: Your rights and responsibilities**SECTION 2 You have some responsibilities as a member of the plan****Section 2.1 What are your responsibilities?**

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 8.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:

Chapter 6: Your rights and responsibilities

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

CHAPTER 7

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

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

BACKGROUND	.....	95
SECTION 1 Introduction	.....	95
Section 1.1	What to do if you have a problem or concern	95
Section 1.2	What about the legal terms?	95
SECTION 2 You can get help from government organizations that are not connected with us	.....	95
Section 2.1	Where to get more information and personalized assistance	95
SECTION 3 To deal with your problem, which process should you use?	.....	96
Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?	96
COVERAGE DECISIONS AND APPEALS	.....	97
SECTION 4 A guide to the basics of coverage decisions and appeals	.....	97
Section 4.1	Asking for coverage decisions and making appeals: the big picture	97
Section 4.2	How to get help when you are asking for a coverage decision or making an appeal	97
Section 4.3	Which section of this chapter gives the details for your situation?	98
SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal	.....	99
Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care	99
Section 5.2	Step-by-step: How to ask for a coverage decision (How to ask our plan to authorize or provide the medical care coverage you want)	100
Section 5.3	Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)	103
Section 5.4	Step-by-step: How a Level 2 Appeal is done	106
Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?	108

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

SECTION 6	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon	109
Section 6.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	109
Section 6.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	110
Section 6.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	113
Section 6.4	What if you miss the deadline for making your Level 1 Appeal?	114
SECTION 7	How to ask us to keep covering certain medical services if you think your coverage is ending too soon	116
Section 7.1	This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services	116
Section 7.2	We will tell you in advance when your coverage will be ending	117
Section 7.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time	118
Section 7.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time	120
Section 7.5	What if you miss the deadline for making your Level 1 Appeal?	121
SECTION 8	Taking your appeal to Level 3 and beyond	124
Section 8.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	124
MAKING COMPLAINTS		125
SECTION 9	How to make a complaint about quality of care, waiting times, customer service, or other concerns	125
Section 9.1	What kinds of problems are handled by the complaint process?	125
Section 9.2	The formal name for “making a complaint” is “filing a grievance”	127
Section 9.3	Step-by-step: Making a complaint	127
Section 9.4	You can also make complaints about quality of care to the Quality Improvement Organization	128
Section 9.5	You can also tell Medicare about your complaint	129

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**BACKGROUND****SECTION 1 Introduction****Section 1.1 What to do if you have a problem or concern**

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 You can get help from government organizations that are not connected with us**Section 2.1 Where to get more information and personalized assistance**

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

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Appendix A of this *Evidence of Coverage*.

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**COVERAGE DECISIONS AND APPEALS****SECTION 4 A guide to the basics of coverage decisions and appeals****Section 4.1 Asking for coverage decisions and making appeals: the big picture**

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

Asking for coverage decisions

A “coverage decision” is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

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

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

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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

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

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

- **You can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at www.TodaysOptions.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government

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

organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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



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

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

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

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

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

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
 - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
 - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

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

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

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

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

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

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

Legal Terms
A “fast coverage decision” is called an “expedited determination.”

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

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

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.

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

- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.***Deadlines for a “fast” coverage decision***

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

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

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

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 5.3	Step-by-step: How to make a Level 1 Appeal (How to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan “ reconsideration. ”

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

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**

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

- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at www.TodaysOptions.com.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

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

Legal Terms
A “fast appeal” is also called an “ expedited reconsideration. ”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this Section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

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

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

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

Deadlines for a “fast appeal”

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

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

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.

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

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

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

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?**

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

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

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

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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

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

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. Read this notice carefully and ask questions if you don’t understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.

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

- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a “fast review”:

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

Legal Terms

A **“fast review”** is also called an **“immediate review”** or an **“expedited review.”**

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Step 2: The Quality Improvement Organization conducts an independent review of your case.*****What happens during this review?***

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

Legal Terms

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

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 6.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision.”

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

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

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

Legal Terms

A “fast review” (or “fast appeal”) is also called an “expedited appeal”.

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

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

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

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

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

- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

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

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

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

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

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an Independent Review Organization reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

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

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

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

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

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

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

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

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

- Home health care services you are getting.
- Skilled nursing care you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 10, *Definitions of important words*.)

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

- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

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

1. You receive a notice in writing. At least two days before our plan is going to stop covering your care, you will receive a notice.

- The written notice tells you the date when we will stop covering the care for you.
- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

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

2. You must sign the written notice to show that you received it.

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

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

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

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

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

Legal Terms
This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.***What happens if the reviewers say yes to your appeal?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

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

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

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal**”.

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

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

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

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

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

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

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

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

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

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**SECTION 8 Taking your appeal to Level 3 and beyond****Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals**

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

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

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

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** – We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** – We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

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

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
- If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

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



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

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

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

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

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

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization.

Chapter 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 9.2 The formal name for “making a complaint” is “filing a grievance”****Legal Terms**

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 9.3 Step-by-step: Making a complaint**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. (866) 568-8921, TTY 711, 8 a.m. to 8 p.m., seven days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Standard Grievances

To use our formal procedures for answering Grievances, you may call Member Services to submit a verbal grievance or you may forward your Grievance in written form to our address noted in Chapter 2, Section 1.

Once we receive your grievance, we will research your complaint. We may contact you also to ask for additional information.

Once we reach a conclusion, we will notify you verbally or by written correspondence if your request is received in writing, if you request a written response, or if your complaint involves quality of care concerns. Our conclusion should reach you within thirty (30) calendar days of receipt of your grievance. However, some cases may require additional time. In those cases, we will notify you of our need for an additional fourteen (14) calendar days to reach a conclusion.

- Expedited Grievances

You may file an expedited grievance orally or in writing should you disagree with our decision not to conduct an expedited organization/Coverage Determination or an expedited reconsideration/redetermination. You may also file an expedited grievance if you disagree with the plan’s decision to request a fourteen (14) calendar day extension to make a decision on an organization determination, coverage determination or reconsideration.

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

You may request an expedited grievance by contacting Member Services at (866) 568-8921. When an expedited grievance is requested, we are required to provide a response within 24 hours.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast” complaint, it means we will give you an answer within 24 hours.

Legal Terms

What this section calls a “**fast complaint**” is also called an “**expedited grievance.**”

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

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

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about *Today's Options Premier 300 (PFFS)* directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1	Introduction	132
Section 1.1	This chapter focuses on ending your membership in our plan	132
SECTION 2	When can you end your membership in our plan?	132
Section 2.1	You can end your membership during the Annual Enrollment Period	132
Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited	133
Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period	133
Section 2.4	Where can you get more information about when you can end your membership?	134
SECTION 3	How do you end your membership in our plan?	135
Section 3.1	Usually, you end your membership by enrolling in another plan	135
SECTION 4	Until your membership ends, you must keep getting your medical services through our plan	136
Section 4.1	Until your membership ends, you are still a member of our plan	136
SECTION 5	<i>Today's Options Premier 300 (PFFS)</i> must end your membership in the plan in certain situations	136
Section 5.1	When must we end your membership in the plan?	136
Section 5.2	We cannot ask you to leave our plan for any reason related to your health	137
Section 5.3	You have the right to make a complaint if we end your membership in our plan	138

SECTION 1 Introduction

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

Ending your membership in *Today's Options Premier 300 (PFFS)* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

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

Section 2.1 You can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
 - Original Medicare *with* a separate Medicare prescription drug plan;

Chapter 8: Ending your membership in the plan

- – *OR* – Original Medicare *without* a separate Medicare prescription drug plan.
- **What do you need to do to switch plans?**
 - If you want to switch to Original Medicare: You must ask to disenroll from our plan. For more information on how to request disenrollment contact Member Services (phone numbers are printed on the back cover of this booklet). You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to request disenrollment from our plan. TTY users should call 1-877-486-2048.
 - If you are currently enrolled in a separate Medicare prescription drug plan:
 - Leaving our plan will not affect your enrollment in your drug plan.
 - If you want to join a new drug plan, you must request enrollment in the new drug plan of your choice. Switching your Medicare prescription drug plan will *not* automatically disenroll you from our plan.
 - If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare health plan that does not offer drug coverage or you can switch to Original Medicare.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

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

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you are enrolled in a separate Medicare prescription drug plan, you may not cancel that coverage when you switch to Original Medicare.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare.

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

In certain situations, members of *Today's Options Premier 300 (PFFS)* may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

Chapter 8: Ending your membership in the plan

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<https://www.medicare.gov>) :
 - Usually, when you have moved.
 - If you have Medicaid.
 - If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
 - Original Medicare *with* a separate Medicare prescription drug plan;
 - – *OR* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

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

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2018* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.

Chapter 8: Ending your membership in the plan

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

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet);
- – *OR* – You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan between October 15 and December 7 You will automatically be disenrolled from <i>Today's Options Premier 300 (PFFS)</i> when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan by December 7 You will automatically be disenrolled from <i>Today's Options Premier 300 (PFFS)</i> when your new plan's coverage begins. • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). Then contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled. • You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

Chapter 8: Ending your membership in the plan

If you would like to switch from our plan to:	This is what you should do:
	<ul style="list-style-type: none"> You will be disenrolled from <i>Today's Options Premier 300 (PFFS)</i> when your coverage in Original Medicare begins. If you join a Medicare prescription drug plan, that coverage should begin at this time as well.
<ul style="list-style-type: none"> Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. 	<ul style="list-style-type: none"> Contact Member Services and ask to be disenrolled from the plan (phone numbers are printed on the back cover of this booklet). You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. You will be disenrolled from <i>Today's Options Premier 300 (PFFS)</i> when your coverage in Original Medicare begins.

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

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

If you leave *Today's Options Premier 300 (PFFS)*, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

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

SECTION 5 *Today's Options Premier 300 (PFFS)* must end your membership in the plan in certain situations

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

***Today's Options Premier 300 (PFFS)* must end your membership in the plan if any of the following happen:**

Chapter 8: Ending your membership in the plan

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

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

Today's Options Premier 300 (PFFS) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

Chapter 8: Ending your membership in the plan

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1	Notice about governing law	141
SECTION 2	Notice about non-discrimination	141
SECTION 3	Notice about Medicare Secondary Payer subrogation rights	141

Chapter 9: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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.

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, *Today's Options Premier 300 (PFFS)*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

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

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient up to 15% more than the plan's payment amount for services. The "balance billing" amount is collected in addition to the patient's regular plan cost-sharing amount. As a member of *Today's Options Premier 300 (PFFS)*, 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. See Chapter 4, Section 1.3 for more information about balance billing.

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

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

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

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

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

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

Chapter 10: Definitions of important words

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

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

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

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

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day. This means you pay \$1 for each day’s supply when you fill your prescription.

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

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

Durable Medical Equipment (DME)– Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems,

Chapter 10: Definitions of important words

diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

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

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

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

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

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

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 income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

Chapter 10: Definitions of important words

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

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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

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

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2018.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the

Chapter 10: Definitions of important words

plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Program of All-inclusive Care for the Elderly (PACE).

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

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

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

Member Services – 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 Member Services.

Network Provider – Providers, such as doctors and other health care professionals, medical groups, hospitals, and other health care facilities, that we have signed contracts with to deliver covered services to members in our plan. These providers have agreed to see members of our plan. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not signed a contract or arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the

Chapter 10: Definitions of important words

high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

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

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

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive “Extra Help,” you will not pay a late enrollment penalty.

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

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

Prior Authorization – Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. In a PFFS plan, you do not need prior authorization to obtain services. However, you may want to check with your plan before obtaining services to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Chapter 10: Definitions of important words

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

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

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

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Appendix A - CONTACT TABLES

SHIP - State Health Insurance Assistance Program

SHIP - State Health Insurance Assistance Program			
State	Agency Name	Contact Information	Web Site
Maine	Maine State Health Insurance Assistance Program (SHIP)	(800) 262-2232 (877) 353-3771 TTY:711 41 Anthony Avenue, Augusta, ME 04333-0011	https://www1.maine.gov/dhhs/oads/community-support/ship.html
New York	Health Insurance Information Counseling and Assistance Program (HIICAP)	(800) 701-0501 TTY: 711 2 Empire State Plaza Albany, New York 12223-1251	https://aging.ny.gov/healthbenefits/

QIO - Quality Improvement Organization (formerly PRO - Peer Review Organization)

QIO-Quality Improvement Organization (formerly PRO - Peer Review Organization)			
State	Agency Name	Contact Information	Web Site
Maine	Livanta	(866) 815-5440 TTY: 1-866-868-2289 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	www.bfccqioarea1.com
New York	Livanta	(866) 815-5440 TTY: 1 (866) 868-2289 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	www.bfccqioarea1.com

State Medical Assistance Office (Medicaid)

State Medical Assistance Office (Medicaid)			
State	Agency Name	Contact Information	Web Site
Maine	MaineCare	(800) 977-6740 TTY:711 11 State House Station, Augusta, Maine 04333-0011	https://www.maine.gov/dhhs/mainecare.shtml
New York	New York State Department of Health	(800) 541-2831 Local: (518) 486-9057 TTY: 711 Corning Tower Empire State Plaza, Albany, NY 12237	https://www.health.ny.gov/health_care/medicaid/

State Health Departments

State Health Departments			
State	Agency Name	Contact Information	Web Site
Maine	Department of Health and Human Services	(207) 287-3707 (207) 287-1890 TTY:711 221 State St., Augusta, ME 04333	https://www.maine.gov/dhhs/
New York	New York State Department of Health	(866) 881-2809 (855) 355-5777 TTY: 711 Corning Tower Empire State Plaza, Albany, NY 12237	https://www.health.ny.gov/

Appendix B - *Today's Options Premier 300 (PFFS)* Service and Premium Table

Today's Options Premier 300 (PFFS)		
State	County	Premium
Maine	Androscoggin	\$0.00
Maine	Aroostook	\$0.00
Maine	Cumberland	\$0.00
Maine	Franklin	\$0.00
Maine	Hancock	\$0.00
Maine	Kennebec	\$0.00
Maine	Knox	\$0.00
Maine	Lincoln	\$0.00
Maine	Oxford	\$0.00
Maine	Penobscot	\$0.00
Maine	Piscataquis	\$0.00
Maine	Sagadahoc	\$0.00
Maine	Somerset	\$0.00
Maine	Waldo	\$0.00
New York	Albany	\$0.00
New York	Allegany	\$0.00
New York	Broome	\$0.00
New York	Cattaraugus	\$0.00
New York	Cayuga	\$0.00
New York	Chautauqua	\$0.00
New York	Chemung	\$0.00
New York	Chenango	\$0.00
New York	Clinton	\$0.00
New York	Columbia	\$0.00
New York	Cortland	\$0.00
New York	Delaware	\$0.00
New York	Erie	\$0.00
New York	Essex	\$0.00
New York	Franklin	\$0.00
New York	Fulton	\$0.00
New York	Genesee	\$0.00

Today's Options Premier 300 (PFFS)		
State	County	Premium
New York	Greene	\$0.00
New York	Hamilton	\$0.00
New York	Herkimer	\$0.00
New York	Jefferson	\$0.00
New York	Lewis	\$0.00
New York	Madison	\$0.00
New York	Monroe	\$0.00
New York	Montgomery	\$0.00
New York	Niagara	\$0.00
New York	Oneida	\$0.00
New York	Onondaga	\$0.00
New York	Ontario	\$0.00
New York	Oswego	\$0.00
New York	Otsego	\$0.00
New York	Rensselaer	\$0.00
New York	St Lawrence	\$0.00
New York	Saratoga	\$0.00
New York	Schenectady	\$0.00
New York	Schoharie	\$0.00
New York	Schuyler	\$0.00
New York	Seneca	\$0.00
New York	Steuben	\$0.00
New York	Sullivan	\$0.00
New York	Tioga	\$0.00
New York	Tompkins	\$0.00
New York	Warren	\$0.00
New York	Washington	\$0.00
New York	Wayne	\$0.00
New York	Wyoming	\$0.00
New York	Yates	\$0.00

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Today's Options® PFFS

A WellCare Company

Today's Options Premier 300 (PFFS) Member Services

Method	Member Services – Contact Information
CALL	(866) 568-8921 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. seven days a week
FAX	(877) 907-2982
WRITE	Today's Options NPFFS P.O. Box 18100 Austin, TX 78760-8100
WEBSITE	www.TodaysOptions.com

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Please see the listing provided in Appendix A at the end of the *Evidence of Coverage* for contact information.

Today's Options® PFFS is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PFFS depends on contract renewal.

This information is available in a different format, including in Spanish. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información está disponible en diferentes formatos, incluyendo el español. Por favor llame a Servicios al Cliente al número indicado arriba si necesita información del plan en otro formato u idioma.

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