Independent Health

January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Independent Health's Encompass 65® (HMO)

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

For questions about this document, please contact Member Services at 716-250-4401 or 1-800-665-1502. (TTY users should call 711.) Hours are October 1 – March 31 Monday - Sunday, 8 a.m. - 8 p.m. and April 1 - September 30 Monday - Friday, 8 a.m. - 8 p.m. This call is free.

This plan, Independent Health's Encompass 65 (HMO), is offered by Independent Health Association, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Independent Health Association, Inc. When it says "plan" or "our plan," it means Independent Health's Encompass 65 (HMO).)

Verbal translation of written materials is available via free interpreter services. For those with special needs, accessibility to benefit information or alternate formats of written materials are available upon request.

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

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

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

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

H3362_C9903_M
H3362_016 Encompass 65 (HMO) No Rx

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

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Independent Health's Encompass 65 (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Independent Health's Encompass 65 (HMO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Independent Health's Encompass 65 (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Independent Health's Encompass 65 (HMO) does not include Part D prescription drug coverage.

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

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

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

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Independent Health's Encompass 65 (HMO).

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

If you are confused or concerned or just have a question, please contact our plan's Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Independent Health's Encompass 65 (HMO) 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 Independent Health's Encompass 65 (HMO) between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Independent Health's Encompass 65 (HMO) after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Independent Health's Encompass 65 (HMO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Independent Health's Encompass 65 (HMO)

Independent Health's Encompass 65 (HMO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

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

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

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

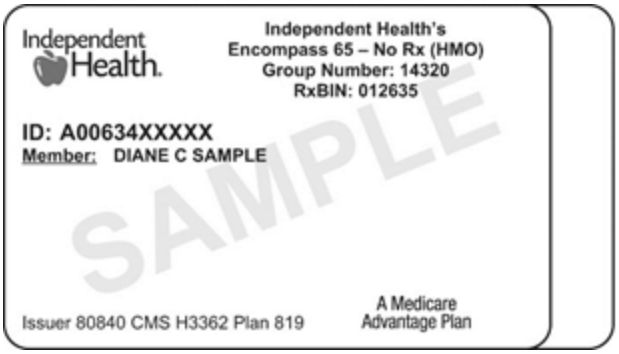
Section 2.3 U.S. Citizen or Lawful Presence

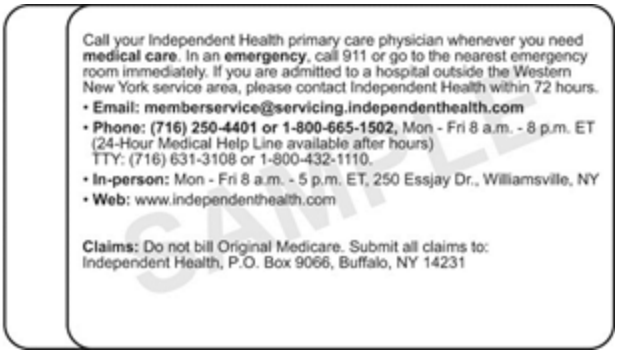
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Independent Health's Encompass 65 (HMO) if you are not eligible to remain a member on this basis. Independent Health's Encompass 65 (HMO)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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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





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

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

Section 3.2 Physician/Provider Directory

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in network), out-of-area dialysis services, and cases in which Independent Health's Encompass 65 (HMO) authorizes use of out-of-network providers.

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

At www.independenthealth.com/individuals-and-families/medicare/find-a-medicare-provider you can view, print and download our physician/provider directories.

- Physician/Provider Directory (and medical dental and vision providers)

- LIBERTY Dental Plan Directory (for routine/preventive dental providers)

- EyeMed "Insight Network" Directory (link to on-line searchable directory for routine/refractive eye exam providers)

- SilverSneakers® Fitness Program participation facility list

- Start Hearing participating network provider listing (for hearing aid fitting evaluation exam and hearing aids)

For the latest up to date information use the search engine under the tab "Find a Doctor" on our website (www.independenthealth.com). You can search for a Provider or facility and print out your results. 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 costs for Independent Health's Encompass 65 (HMO)

Your costs may include the following:

- Plan Premium (Section 4.1)

- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov/medicare-and-you). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Independent Health's Encompass 65 (HMO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Medicare Part B Premium Reduction

As you know, your Medicare Part B premium is automatically deducted from your monthly Social Security check. While you are enrolled in this plan, Independent Health will pay up to $20 of your Medicare Part B premium. As a result, your monthly Social Security check will increase by this amount. You do not have to complete any paperwork to receive this benefit. We will take care of that for you. It could take several months for the Social Security Administration to complete their processing. This means you may not see the increase in your Social Security check for several months after the effective date of this plan. Any missed increases will be added to your next check after processing is complete. Please note that if you disenroll from this plan, your Medicare Part B premium give back will end on the date of disenrollment. As mentioned above, it could take several months for the Social Security Administration to complete their processing. Any premium reductions you receive after you disenroll will eventually be deducted from your Social Security check.

SECTION 5 More information about your monthly premium

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

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

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Member Services.

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

SECTION 7 How other insurance works with our plan

Other Insurance

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

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays

first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

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

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Independent Health's Encompass 65 (HMO) contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Independent Health's Encompass 65 (HMO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	**1-800-665-1502 or 716-250-4401** Calls to this number are free. Hours of operation (Eastern time): October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. After business hours and on Saturdays, Sundays, and holidays please leave a message. Callers should include their name, phone number and the time they called, and a representative will return their call no later than one business day after they leave a message. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
FAX	716-631-1039
WRITE	511 Farber Lakes Drive, Buffalo, NY 14221 medicareservice@servicing.independenthealth.com
WEBSITE	www.independenthealth.com/medicare

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

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

Method	Coverage Decisions for Medical Care – Contact Information
CALL	**1-800-665-1502 or 716-250-4401** Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. After business hours and on Saturdays, Sundays, and holidays please leave a message. Callers should include their name, phone number and the time they called, and a representative will return their call no later than one business day after they leave a message.
TTY	**711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
FAX	**716-635-3504**
WRITE	Medical Coverage Determinations: Independent Health Appeals and Complaints P.O. Box 2090 Buffalo, NY 14231 email: Appeals@independenthealth.com
WEBSITE	www.independenthealth.com/medicare

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

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

Method	Complaints about Medical Care – Contact Information
CALL	**1-800-665-1502 or 716-250-4401** Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. After business hours and on Saturdays, Sundays, and holidays please leave a message. Callers should include their name, phone number and the time they called, and a representative will return their call no later than one business day after they leave a message.
TTY	**711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
FAX	**716-635-3504**
WRITE	Independent Health Appeals and Complaints P.O. Box 2090 Buffalo, NY 14231 email: Appeals@independenthealth.com
MEDICARE WEBSITE	You can submit a complaint about Independent Health's Encompass 65 (HMO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information	
CALL	**1-800-665-1502 or 716-250-4401** Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. Calls to this number are free.	
TTY	**711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.	
FAX	**716-635-3855**	
WRITE	**For Medical Claims:** Independent Health PO Box 9066 Buffalo, NY 14231-9066 Attn: Claims Department	**For Dental Claims:** LIBERTY Dental Plan P.O. Box 15149 Tampa, FL 33684 **For Vision Claims:** EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
WEBSITE	www.independenthealth.com/Medicare	

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

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

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

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

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York's SHIP) - Contact Information
CALL	HIICAP Hot Line: 1-800-701-0501
TTY	Dial 711
WRITE	Health Insurance Information, Counseling, and Assistance Program New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251 NYSOFA@aging.ny.gov
WEBSITE	www.aging.ny.gov

HIICAP Local Offices	
Allegany County Office for the Aging Anita Mattison, Director 6085 Route 19 N Belmont, NY 14813 585-268-9390	**Genesee County** Office for the Aging Diana Fox, Director Batavia-Genesee Senior Center 2 Bank Street Batavia, NY 14020-2299 585-343-1611

HIICAP Local Offices	
Cattaraugus County Department of the Aging Catherine M. Mackay, Director One Leo Moss Drive, Suite 7610 Olean, NY 14760-1101 716-373-8032	**Niagara County** Office for the Aging Darlene DiCarlo, Director 111 Main Street, Suite 101 Lockport, NY 14094-3718 716-438-4020
Chautauqua County Office for the Aging Dr. Mary Ann Spanos, Director 7 North Erie Street Mayville, NY 14757 716-753-4471	**Orleans County** Office for the Aging Melissa Blanar, Director County Administration Building 14016 Route 31W Albion, NY 14411-9382 585-589-3193
Erie County Department of Senior Services Angela Marinucci, Commissioner 95 Franklin Street, Room 1329 Buffalo, NY 14202-3985 716-858-8526	**Wyoming County** Office for the Aging Andrea Aldinger, Deputy Director 8 Perry Avenue Warsaw, NY 14569 585-786-8833

SECTION 4 Quality Improvement Organization

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta (New York's Quality Improvement Organization) – Contact Information – Contact Information
CALL	1-866-815-5440

Method	Livanta (New York's Quality Improvement Organization) – Contact Information – Contact Information
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO Area 2 10830 Guilford Rd., Suite 312 Annapolis Junction, MD 20701
FAX	1-855-236-2423
WEBSITE	www.livanta.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 getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

SECTION 6 Medicaid

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

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

To find out more about Medicaid and its programs, contact New York State's Department of Social Services.

Method	Department of Social Services (New York's Medicaid program) – Contact Information
CALL	Your local Department of Social Services (See below)
WRITE	New York State Department of Health Corning Tower Empire State Paza Albany, NY 12237
E-MAIL	medicaid@health.ny.gov
WEBSITE	www.health.ny.gov

Local Departments of Social Services: www.ocfs.state.ny.us	
Allegany County Allegany County DSS 7 Court Street County Office Building, Rm. 127 Belmont, New York 14813-1077 (585) 268-9622	**Genesee County** Genesee County DSS 5130 East Main Street, Suite #3 Batavia, New York 14020 (585) 344-2580
Cattaraugus County (Main Office) Cattaraugus County DSS Cattaraugus County Building One Leo Moss Drive Suite 6010 Olean, New York 14760-1158 (716) 373-8065	**Niagara County** Niagara County DSS 20 East Avenue PO Box 506 Lockport, New York 14095-0506 (716) 439-7600
Chautauqua County Chautauqua County DSS 3 N. Erie St.Hall R. Clothier Building Mayville, New York 14757 (716) 753-4998	**Orleans County** Orleans County DSS14016 Route 31 West Albion, New York 14411-9365 (585) 589-7000
Erie County Erie County DSS Edward A. Rath County Office Building 95 Franklin Street, 8th Floor Buffalo, New York 14202-3959 (716) 858-8000	**Wyoming County** Wyoming County DSS 466 North Main Street Warsaw, New York 14569-1080 (585) 786-8900

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them

know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

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

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

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

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

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

As a Medicare health plan, Independent Health's Encompass 65 (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Independent Health's Encompass 65 (HMO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network

provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*

- The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. **Authorization must be obtained from the plan's Medical Director prior to seeking care.** In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

When you become a member of our Plan, you must choose a network provider to be your PCP. Your PCP is a Primary Care Physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will receive your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. Even though **YOU DO NOT NEED A REFERRAL TO SEE A SPECIALIST** we encourage the specialist to communicate back to your PCP. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- your x-rays
- laboratory tests
- therapies

- care from doctors who are specialists
- hospital admissions, and
- follow-up care.

What types of providers may act as a PCP?

Any Primary Care Physician who meets state requirements and is trained to give you basic medical care and is listed in our Physician/Provider Directory as a primary care physician. If your PCP specializes solely in Internal Medicine, General Practice, Family Practice, Geriatrics, Pediatrics or Obstetrics/ Gynecology, you may get your routine care from a PCP for a lower copayment. If your PCP (or a covering physician that your primary care physician asks you to see in his or her absence) has a secondary specialty other than Internal Medicine, General Practice, Family Practice, Geriatrics, Pediatrics, or Obstetrics/Gynecology, you will be required to pay the specialist copayment associated with this physician visit. Please refer to your Physician/Provider Directory for a listing of physicians designated as PCPs. A PCP may also coordinate the rest of the covered services you get as a plan member. However, an OB/GYN cannot perform the Enhanced Annual Wellness Visit (see Chapter 4).

What is the role of the PCP in coordinating covered services?

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP. In some cases, your PCP will need to get **prior authorization** (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose your PCP?

Your selection for your PCP should be indicated on your enrollment application. To choose your Primary Care Physician, simply select one from the Physician/Provider Directory. It is always advisable to check with the physician's office to confirm that they will accept new patients. (You can also use our most up-to-date on-line "Find-A-Doctor" tool on our website at www.independenthealth.com/Medicare.) or call Member Services at the number on the back of this book.

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

If you want to be admitted to a particular network hospital, it is also wise to inquire at which network hospital(s) your Primary Care Physician has admitting privileges. **Since your Primary Care Physician will provide and coordinate your medical care, you must have all of your past medical records sent to your new Primary Care Physician's office.** If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Changing your PCP

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

To change your PCP, call Member Services.

Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They may also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

You can also change your PCP on our website at www.independenthealth.com. You must first log in to access your account and tell us who your new PCP is.

Don't have a personal online account? You can register online using your Independent Health Member ID card. Find the "Register" button near the member login and complete the registration process by entering your information.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots (or vaccines), COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- All other medically necessary Medicare-covered services. Restrictions apply. See the specific benefit in Chapter 4.

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

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

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

Sometimes services require provider preauthorization. This is the responsibility of your network provider. It ensures that the services you receive will be covered. Failing to do so could leave you responsible for the cost if the service is deemed not medically necessary, experimental, or is being performed by a provider without the appropriate credentialing. If we say we will not cover the service, you have a right to appeal the decision. See Chapter 7, Section 4 about coverage decisions.

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

When your PCP thinks that you need specialized treatment, he/she may recommend a Plan specialist or other providers. **(You do NOT need a referral from your PCP to see an in-network specialist.)**

For some types of services, your PCP may need to get approval in advance from our Plan's Utilization Management Department (this is called getting "**provider preauthorization**"). See Chapter 4, Section 2.1 for services requiring prior authorization.

The selection of a PCP does not result in being limited to specific specialists or hospitals to which that PCP refers, i.e. sub-network, referral circles.

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

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves 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 notify you that your provider is leaving our plan so that you have time to select a new provider.

If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.

- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Authorization **must** be obtained from the plan's Medical Director prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider, or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Notice is sent to members as follows:

- In the case where a PCP terminates a contract with Independent Health, even if the PCP is a member of a group whose contract with Independent Health continues, then at least 30 calendar days prior to the effective termination date, Independent Health sends written notice by regular mail to each member who designated the provider as their PCP of record.
- In the case where Independent Health terminates a provider's contract due to a practitioner's death, notice is sent within fifteen (15) days of the date that Independent Health becomes aware of the practitioner's change of status.

If this happens, you will have to switch to another provider who is part of our Plan. Member Services can assist you in finding and selecting another provider.

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

As a plan member, you may obtain pre-authorization to a **non-network provider**, if all the following are met:

- There is no network provider with appropriate training and experience to meet your particular health care needs.
- The care or services are medically necessary.
- Prior written authorization was obtained from the Medical Director. Your Primary Care Physician will obtain such authorization.

- Independent Health covers dialysis services for ESRD enrollees who have traveled outside the plans service area and are not able to access contracted ESRD providers.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. This plan also provides a supplemental benefit which covers emergency medical care worldwide, whenever you need it. If you receive emergency or urgently-needed services outside of the Unites States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

- **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. Call the phone number on the back of your Independent Health membership card. The phone number is also on the back cover of this book.

What is covered if you have a medical emergency?

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

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over. Post stabilization care is not covered outside of the country.

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

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.
- *or* – The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

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

Your primary care physician can also provide or arrange for all non-emergency and urgently needed care. All Independent Health physicians are required to either be available or provide for an on-call physician 24 hours a day, 7 days a week. If you cannot reach your physician or his or her on-call physician, contact Independent Health's Member Services (Phone number is on the back of this book) or our 24-Hour Medical Help Line at **1-800-665-1502** for assistance. (TTY users call 711.) Urgent care is also available at urgent care centers and/or walk-in clinics.

- **If you can't reach your Primary Care Physician, call our 24-hour Medical Help Line: 1-800-665-1502** (TTY users: 711) Access to experienced registered nurses 24 hours a day, 7 days a week for non-emergency medical issues and advice and Treatment Decision Support.
- You can receive urgent care from an urgent care center or walk-in clinic.
- Use our web tool to locate an urgent care centers near you www.independenthealth.com/Findadoc.
- Find an urgent care center via our Mobile app. To download the app to your Smartphone, visit www.independenthealth.com/MobileAppMyIH

Independent Health's Telemedicine Program:

We cover online internet consultations between you and providers who participate in our telemedicine program for medical conditions that are not an Emergency Condition. To receive this benefit you must call Teladoc. See Chapter 4.

Independent Health's telemedicine program is an online video or phone consultation service administered by U.S. board-certified physicians including family practitioners, PCPs, pediatricians and internists, who use electronic health records to diagnose and treat conditions, including writing prescriptions. Independent Health's telemedicine service provides coverage within the U.S. service area and anywhere in the world where there is internet access. Independent Health's telemedicine benefit should not be used if you are experiencing a medical emergency. The service is intended to provide a solution for non-emergency medical situations. The service is not intended to replace your primary care physician/patient relationship but rather offer you an alternative option to an urgent care facility or when you are unable to obtain services from your primary care physician for many common medical issues including but not limited to:

- Cold and flu symptoms
- Bronchitis
- Allergies
- Poison ivy
- Eye infections/Pink eye
- Urinary tract infection
- Respiratory infection
- Strep throat
- Sinus problems

Consultation Access:

- You create an account online. You have the option of requesting a phone or video consultation.
- Account creation involves completing baseline health information such as providing a medical history, allergy information, list of medications, health problems, family history and Primary Care Physician contact information.

- A U.S. board-certified physician will review your electronic health record, then will contact you to discuss health care concerns.
- The physician recommends the appropriate treatment for your medical issue
- If necessary, the doctor may prescribe medication for your diagnosis. Prescriptions for short-term antibiotics, antihistamines or anti-bacterial agents can be sent to your preferred pharmacy. Nearly all of the drugs prescribed are generic. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. See Chapter 4 for details about your cost share.
- The prescription is sent to a pharmacy of your choice following the consultation. You are responsible for 100% of the total cost of any prescription prescribed by the Teledoc provider because this plan does NOT include Part D drugs.
- Your credit card is charged the applicable cost sharing and a receipt for services is provided upon request. See Chapter 4 for details about your cost share.
- The physician updates your electronic health record based upon the consult.
- At the end of the consultation you are asked if you would like your information forwarded to your PCP; based on your approval the information is then forwarded to your PCP.
- The service is available 24/7 and may be accessed if traveling throughout the U.S and anywhere in the world where there is internet access.
- We also offer Teladoc via a smart phone or tablet app anywhere in the world where there is internet access. Download the app from www.teladoc.com/ih to your smart phone or tablet, create your account and you'll have access to a doctor from your home state from most places in the world, including on cruise ships, within 60 minutes. If you have already created your account, you can access Global Care through it. If it is appropriate for your health condition, a prescription recommendation will be sent to you that you can take to a pharmacy. There is a CMS regulation that prohibits Independent Health or Medicare from covering the cost of any Part D prescription drug when it's purchased outside of the United States or its' territories.

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

We cover Emergency, Urgent care, and Ambulance services out of the country. Please see the Benefits Chart in Chapter 4 for cost sharing and limitations.

Worldwide unforeseen care is subject to a maximum plan benefit limit of $10,000 per occurrence for coverage outside of the USA. Coverage ends when the $10,000 limit is reached.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.independenthealth.com/IndividualsFamilies/Medicare/MedicareMemberResources for information on how to obtain needed care during a disaster.

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

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

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

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

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

Independent Health's Encompass 65 (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out of network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward an out-of-pocket maximum.

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

Section 5.1 What is a clinical research study?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Do you want to know more?

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

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

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

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

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

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

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

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

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

See the Benefits Chart in Chapter 4 for Inpatient Hospital coverage limits.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Independent Health's Encompass 65 (HMO), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

Under certain limited circumstances we will transfer ownership of the DME item to you after 10 months. Call Member Services for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Independent Health's Encompass 65 (HMO) will cover:

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

If you leave Independent Health's Encompass 65 (HMO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

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

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Independent Health's Encompass 65 (HMO). 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:

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out of pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2025 this amount is $6,750.

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $6,750, you will not have to pay any out-of-pocket costs for the rest of the year for in-network 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 Our plan also limits your out-of-pocket costs for certain types of services

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

The plan has a maximum out-of-pocket amount of $750 for covered Inpatient Hospital care. Once you have paid $750 out-of-pocket for covered Inpatient Hospital care, the plan will cover these services at no cost to you for the rest of the calendar year. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for Inpatient Hospital care apply to your covered Inpatient Hospital care. This means that once you have paid *either* $6,750 for Part A and Part B medical services *or* $750 for your Inpatient Hospital care, the plan will cover your covered Inpatient Hospital care at no cost to you for the rest of the year.

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

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

Here is how this protection works:

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

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

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

The Medical Benefits Chart on the following pages lists the services Independent Health's Encompass 65 (HMO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold (**Requires Provider Preauthorization**).
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart. Independent Health uses the frequency guidelines adopted by CMS and the U.S. Preventive Services Task Force (USPSTF). Additional screenings would require a member to pay a copayment or coinsurance. Preventive screenings and exams focus on evaluating your current health status when you are symptom free. The USPSTF has identified what these screenings are and the appropriate frequency for the test to be repeated. Diagnostic tests are medical evaluations to help manage or treat an existing specific health condition.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Annual Out of Pocket Maximum	Copayments and coinsurance are limited to a $6,750 out-of-pocket maximum in-network. Optical dispensing, routine eye exams, routine eyewear cost in excess of annual limit, preventive/routine dental, comprehensive dental, hearing aid evaluation exam, and hearing aids do NOT count towards the out-of-pocket maximum.
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening
Acupuncture for chronic low back pain	$10 copayment

Services that are covered for you	What you must pay when you get these services
Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: **For the purpose of this benefit, chronic low back pain is defined as:** • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a	

Services that are covered for you	What you must pay when you get these services
physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	(Provider preauthorization is required for planned transportation only) $150 copayment for each Medicare-covered service or one-way trip by ground transportation. 20% coinsurance for each Medicare-covered air transportation. Copayment applies for evaluation, treatment, or transportation to the hospital for each Medicare-covered one-way trip. The copayment is NOT waived even if you are admitted to a hospital as an inpatient immediately following the ambulance transport. Wheelchair van, stretcher van and ambulette transportation are not covered. **Outside United States and its territories:** Worldwide coverage: Maximum plan benefit limit of $10,000 per occurrence for the unforeseen event outside of the USA. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current	There is no coinsurance, copayment, or deductible for the annual wellness visit. The annual wellness visit cannot be performed by an OB/GYN.

Services that are covered for you	What you must pay when you get these services
health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	Certain services rendered during a routine exam may take a copayment, for example, a diagnostic test. **Annual Physical Exam** (also known as the "Enhanced Annual Visit"). As a member of our Plan, you can receive an annual "Enhanced Annual Visit" also referred to as an "EAV". Only your chosen PCP currently on record with Independent Health can perform and bill for the annual EAV. **You can receive an annual EAV one (1) time per calendar year. Once you have the EAV performed during the plan calendar year, the benefit is exhausted.** If you change your primary care physician (PCP) during the plan year, another EAV is not covered and you may be liable for the cost of the service. Our Medicare HMO plans require you to choose a primary care physician (PCP) who will provide most of your care and arrange/coordinate the covered services you get as a member of our Plan including the EAV. The EAV is a supplemental benefit that includes services beyond an Annual Wellness Visit. The EAV includes a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all the body systems as well as a full examination to assess your overall general health and detect any abnormalities or signs that could indicate a disease process that should be addressed. The visit may

Services that are covered for you	What you must pay when you get these services
	also include the completion of a Health Risk Assessment and a discussion regarding potential gaps in care that need to be addressed to meet your individual needs. If your provider is not able to perform the EAV or you are unable to obtain an EAV, please contact Independent Health and we will assist with scheduling a convenient in-home EAV on your provider's behalf. OB/GYN's are not eligible to perform the EAV.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms. 3D Tomography is covered in full if part of the preventive screening

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for Medicare-covered cardiac rehabilitation services. Limited to 36 visits per cardiac occurrence.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. Lab test covered in full for each Medicare-covered screening. However, if you are treated or monitored for a new or an existing

Services that are covered for you	What you must pay when you get these services
• 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	medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • We cover certain non-Medicare covered Evaluation and Management services above and beyond subluxation of the spine. Covered services are the evaluation of a new or existing patient with low to moderate complexity and medical decision making to assess a member's condition and create or modify a plan of care.	$10 copayment per visit for covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. Separate office visit cost sharing may apply: (i.e., pre and post procedure consultations): $0 copayment in a Primary Care Physician's office

Services that are covered for you	What you must pay when you get these services
• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	$10 copayment in a Specialty Physician's office However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office Serum (blood testing) colorectal cancer screening has a primary care provider copayment and a $10 copayment specialty care provider copayment.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Routine Preventive Dental from a LIBERTY Dental Plan network provider:** **Limitations:** • Oral exams are limited to 2 every year. • Routine cleanings are limited to 2 every year. • Fluoride treatments are limited to 2 every year.	**Medicare-covered Dental:** $10 copayment for Medicare-covered dental services by a Specialist Physician. **Other Dental Services:** $2,000 annual plan benefit maximum per year for routine, preventive and comprehensive dental services. Once the annual plan benefit maximum is met, additional dental services are not covered. Comprehensive Dental Services are subject to $0 deductible and 50% coinsurance on covered services.

Services that are covered for you	What you must pay when you get these services
• Bitewing x-rays are limited to twice in any calendar year. • Full mouth x-rays are limited to once every 36 months. **COMPREHENSIVE DENTAL** Covers additional dental services, for example: Periodontal cleaning Crowns Dentures Extractions See Section 3 of this chapter for a complete list of covered services. You cannot combine any other promotional offers with our comprehensive dental benefit. This benefit is administered by LIBERTY Dental Plan. You must use a LIBERTY Dental Plan provider. For claims, eligibility and benefit questions, call LIBERTY Dental Plan customer service department toll-free at 1-888-352-7811. TTY users call 1-877-855-8039. Customer service representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Standard Time). LIBERTY Dental Plan P.O. Box 15149 Tampa, FL 33684 Website: www.libertydentalplan.com Scheduling Appointments After you have selected a LIBERTY Dental Plan dentist, call the dentist's office to schedule an appointment. Tell the dentist you are covered by LIBERTY Dental Plan network for Independent Health's Medicare Advantage plans and ask the dentist to confirm that he or she is a participating provider in the network.	$0 copayment for each routine preventive dental exam, cleaning, fluoride treatment, and x-ray (See limitations in left hand column) at participating providers in LIBERTY Dental Plan's network for Independent Health's Medicare Advantage plans. If you visit a dentist that is not in our dental network, you will be responsible for 100% of the cost. Member cannot combine any promotional offers with our dental benefit. **Enrollee Liabilities** You must pay for any non-covered or optional dental services that you choose to have done. This program is designed to cover diagnostic and preventive dental treatment that is consistent with good professional practice. You will be responsible for services you receive that are not covered benefits as listed in this EOC and services received that are greater than the limits specified in this EOC. To find a network dental provider, see our LIBERTY Dental Plan Dental Directory at independenthealth.com/Medicare or contact member services at the number on the back of this book.
 **Depression screening**	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services
We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • **Blood Glucose Monitor and Devices**	**(Certain items may require provider preauthorization)** Supplies used with the administration of insulin are covered under Part D (i.e., syringes). This plan does not have Part D coverage, including Omni-pod and Part D insulins. $0 copayment for blood glucose monitor.

Services that are covered for you	What you must pay when you get these services
• **Lancets**	Limited to preferred products such as OneTouch® manufactured by Lifescan: • OneTouch® Verio Flex™ • OneTouch® Verio® • OneTouch® Verio® IQ • OneTouch® UltraMini™ • OneTouch® Ultra®2 0% coinsurance for each 30 day supply of Medicare-covered lancets. Limited to preferred products such as OneTouch® manufactured by Lifescan: • OneTouch Delica Lancets • OneTouch Ultrasoft Lancets • Lifescan Fine Point Lancets
• Supplies to monitor your blood glucose: Blood glucose test strips and glucose-control solutions for checking the accuracy of test strips and monitors.	0% coinsurance per item for each 30-day supply. Limit 100 test strips per 30-day supply. Blood glucose test strips limited to preferred products manufactured by Lifescan: • OneTouch® Verio® Test Strips • OneTouch® Ultra® Test Strips
• **Continuous glucose monitor and supplies**	$0 copayment for therapeutic continuous glucose monitor, transmitters, sensors, and supplies. 20% coinsurance for non-therapeutic continuous glucose monitor. 20% coinsurance for supplies used with a non-therapeutic continuous glucose monitor. Limited to preferred continuous glucose monitors and supplies. These are no longer covered

Services that are covered for you	What you must pay when you get these services
	through medical supply or durable medical equipment providers and only covered through network pharmacies. Omni-pod is not covered.
• **For people with diabetes who have severe diabetic foot disease:** One pair per calendar year of therapeutic off the shelf or custom-molded depth-inlay shoes (including multiple-density inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth-inlay shoes and three pairs of multiple-density inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	$0 copayment for Medicare-covered therapeutic custom-molded shoes and inserts as listed in left column.
• **Diabetes self-management training is covered under certain conditions.**	Covered in full
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.independenthealth.com/Medicare.	**(Certain items may require provider preauthorization)** 10% coinsurance for certain mobility devices from our preferred DME provider, People First Mobility. 20% coinsurance for all other covered DME items. For certain mobility devices, contact People First Mobility Phone: 716-566-5000 Fax: 716-877-1371 Address: 800 Hertel Ave Suite 103, Buffalo NY 14207 Email: Contact@peoplefirstmobility.net Website: www.peoplefirstmobility.net Please see Section 3.1 of this chapter for additional information on DME coverage.

Services that are covered for you	What you must pay when you get these services
	Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month. No cost share will apply for the remainder of the 5-year reasonable useful lifetime of the equipment (month 37 through 60). Once the 5-year reasonable useful lifetime of the equipment has passed (month 61), a new 36 month rental period may begin and you will be charged the cost share for Durable Medical Equipment for next 36 months. If prior to enrolling in Independent Health's Encompass 65 you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Independent Health's Encompass 65 is 20% coinsurance.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	$125 copayment per Emergency room visit within or outside the service area. The copayment is waived if you are admitted as an inpatient within 24 hours after the ER visit for the same condition to the same hospital. The copayment is waived if admitted during the current visit. If the member leaves the facility and returns, and is then admitted, they will owe the ER copayment for the first ER visit, but the second ER visit is waived upon admission. If you receive emergency care at an out-of-network hospital and need inpatient care after your

Services that are covered for you	What you must pay when you get these services
As a supplemental benefit, we cover emergency/urgent coverage worldwide.	emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. If you go to the ER and are placed in the "Observation" status, we will waive your ER copay and the Observation copay will apply. **Outside United States and its territories:** Worldwide coverage: Maximum plan benefit limit of $10,000 per occurrence for unforeseen care outside of the USA and its territories. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share.
Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. • **Medicare HealthStyles Newsletter** Once annually, Independent Health publishes a member newsletter, which includes articles, tips and other information aimed at keeping members healthy. • **24-hour Medical Help Line: 1-800-665-1502 (TTY users: 711)** Access to experienced registered nurses 24 hours a day, 7 days a week for non-emergency medical issues and advice and Treatment Decision Support.	$20 copayment for certain community health education classes. $0 copayment for all other Health and Wellness education programs

Services that are covered for you	What you must pay when you get these services
• **Health and Wellness Classes** Educational seminars and classes offered by community providers which address a variety of health related topics. There are fitness education programs and non-fitness programs for members to take part in. A calendar of events is available on Independent Health's website, www.independenthealth.com or by calling Member Services at the number on the back cover of this document. • **Health Education: Brook and Brook+** Brook is a smartphone app that provides 24/7 health coaching expertise and support for general health and chronic conditions like diabetes and hypertension. Brook helps you make daily health decisions, track your nutrition, medications, sleep, activity and more. Brook+, a diabetes prevention program, is also offered to members with pre-diabetes through the Brook Platform. • **Rewards and Incentives** - Access to a personalized rewards and incentive program that provides rewards to enrollees in connection with participation in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources, with the goal of improving and sustaining overall health and well-being and addressing gaps in care. More information including how to participate in the program can be easily accessed by visiting Independenthealth.com/Medicare. • **Fall Risk Assessment** A comprehensive 6-month program in partnership with Western New York Integrated Care Collaborative in which members meet with a Health Coach in their home to help reduce the risk of falls. • **Case Management and Disease Management** Independent Health offers case management services to assist and coordinate care, based on a member's health needs. Services are coordinated by health professionals, who provide information on a variety of conditions, such as Asthma,	

Services that are covered for you	What you must pay when you get these services
Diabetes, Coronary Artery Disease, Congestive Heart Failure, COPD, Depression, Maternity Management and other life changing health events. Members are educated and encouraged on how to take an active role in managing their health. Additional Case Management Services, including frail elderly and palliative care, are available to assist members with complex care needs, who are discharged from the hospital and/or living at home with declining physical functioning relating to chronic and serious illnesses. These services provide support and linkage to resources to optimize a member's independence and comfort. Members may request a case management evaluation by calling member services and ask to speak with the Case Management Department. The phone number is on the back cover of this book and on your Member ID card.	
• **Fitness Program:** Fitness membership	SilverSneakers® $0 copayment. SilverSneakers gives you FREE access to: • Thousands of participating fitness center locations nationwide[1] • SilverSneakers Live classes and workshops taught by instructors trained in senior fitness • 200+ workout videos in the SilverSneakers On-Demand™ online library • SilverSneakers GO™ mobile app with digital workout programs • Burnalong® access with a supportive virtual community

Services that are covered for you	What you must pay when you get these services
	and thousanads of classes for all interests and abilities • GetSetUp, with hundreds of interactive online classes one hour or less, ranging from nutrition to mindfulness and more. You must use participating SilverSneakers fitness locations and programs. For a list of participating fitness facilities, go to www.silversneakers.com. Or call SilverSneakers (toll free) at 1-888-313-5653 (TTY: 711) or Independent Health Member Services at 800-665-1502 or 716-250-4401 (TTY: 711) Memberships will not roll over from plan year to plan year. Memberships will restart on January 1st of each year. Benefit may change on January 1st of each year.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Routine Hearing Exams • Hearing aids and evaluation to see if you need a hearing aid. • Benefit is limited to the preferred hearing aids through a provider in the Start Hearing network, which come in various styles and colors Hearing Aid purchase includes: • Fittings for hearing aids: 6 provider visits within the first year of hearing aid purchase	$0 copayment in a Primary Care Physician's office for a Medicare-covered or routine hearing exam $10 copayment in a Specialty Physician's office for a Medicare-covered or routine hearing exam $45 copayment per exam for a fitting and evaluation hearing aid exam from a provider in the Start Hearing network. Copayment Structure per hearing aid: $499, $699, $999, $1,499, or $1,949. Benefit is limited to preferred hearing aids, which come in various styles and colors. You

Services that are covered for you	What you must pay when you get these services
• 60 day trial purchase • 2 year extended warranty for each hearing aid priced at $499 • 3 year extended warranty for each hearing aid priced at $699, $999, $1,499 or $1,949. • Rechargeable and non-rechargeable models available. • Non-rechargeable models include 40 batteries per hearing aid • Loss and damage warranty claims ($250 each hearing aid) Benefit does not include or cover any of the following: • Ear molds • Hearing Aid accessories • Additional provider visits • Extra batteries • Hearing Aids that are not through a provider in the Start Hearing network. **Costs associated with excluded items are the responsibility of the member and not covered by the plan.**	must see a network provider to use this benefit. Hearing aid evaluation exam and hearing aid copayments are not subject to the maximum out-of-pocket. Member cannot combine any promotional offers with our hearing aid benefit.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office

Services that are covered for you	What you must pay when you get these services
	$10 copayment in a Specialty Physician's office
Home delivered Meals Home delivered meals for consecutive days (up to a maximum of meals total) within 30 days of discharge from an overnight stay in a hospital or skilled nursing facility. Meal Delivery must be coordinated through a discharge planner at the facility or by calling Independent Health Member Services at the phone numbers on the back of this booklet. Meals must be delivered in the 8 counties of Western New York.	$0 copayment Covered for up to 28 meals delivered to the member's home for 14 consecutive days following an overnight stay in a hospital or skilled nursing facility.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**(Provider preauthorization may apply for some services)** $0 copayment for Home Health agency care. Supplies are covered in full when medically necessary. 10% coinsurance to 20% coinsurance for Medicare-covered durable medical equipment and supplies. See Durable Medical Equipment in this benefit chart for more details.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services. furnished in accordance with the plan of care	$0 copayment for home infusion services. See Medicare Part B Drugs for home infusion drug cost share.

Services that are covered for you	What you must pay when you get these services
• Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis</u>: If	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal diagnosis are paid for by Original Medicare, not Independent Health's Encompass 65 (HMO). Must be a Medicare-certified Hospice.

Services that are covered for you	What you must pay when you get these services
you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) <u>For services that are covered by Independent Health's Encompass 65 (HMO) but are not covered by Medicare Part A or B</u>: Independent Health's Encompass 65 (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Office visit copayment may apply for hospice consultation services. $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment

Services that are covered for you	What you must pay when you get these services
• Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines	will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
• Other vaccines if you are at risk and they meet Medicare Part B coverage rules • We also cover some vaccines under our Part D prescription drug benefit.	20% coinsurance for other Part B vaccines if you are at risk
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have	$150 copayment per day for days 1 through 5 per benefit period. $0 copayment per day for additional days. Unlimited days for Medicare-covered stays. Subject to $750 annual copayment maximum. Copayment applies on the date of admission but not on the date of discharge. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. The inpatient copayment does not apply if you are readmitted to a hospital within 60 days of your discharge from a hospital, even if the discharge occurred in the previous calendar year. Otherwise, your hospital copay applies on the date of admission.

Services that are covered for you	What you must pay when you get these services
your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Independent Health's Encompass 65 (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion • Blood - including storage and administration. 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. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You are responsible for the maximum number of per day cost shares for each benefit period. If you are discharged from the hospital prior to using the maximum number of per day cost shares, and if you are readmitted during the benefit period, you will still be responsible for the remaining number of per day cost shares during that benefit period. You will not be responsible for more than the maximum number of per day cost shares per benefit period. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost sharing you would pay at a network hospital.
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to	**(Requires provider preauthorization except for emergency admissions)** $250 copayment per day for days 1 through 6 per benefit period.

Services that are covered for you	What you must pay when you get these services
inpatient mental health services provided in a psychiatric unit of a general hospital.	$0 copayment per day, days 7 through 90. Cost sharing is charged for each inpatient stay. Copayment applies on the date of admission but not on the date of discharge. A benefit period begins the day you go into a hospital. The benefit period ends when you haven't received any inpatient hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. The inpatient copayment does not apply if you are readmitted to a hospital within 60 days of your discharge from a hospital, even if the discharge occurred in the previous calendar year. If you get authorized inpatient mental health care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost sharing you would pay at a network hospital.
Inpatient vs. Outpatient Level of Care i.e. Observation Bed When you go to the hospital to seek emergency medical attention, you will be seen by a physician in the emergency room who will assess your current medical condition and care needs. This doctor is referred to as the 'attending' physician. The attending physician will determine whether or not your condition is stable for discharge from the emergency room to return to your residence; or, if additional care is medically necessary. Although you may physically be in the hospital, your medical needs may not require an acute inpatient level of care. Instead, you may require what is	

Services that are covered for you	What you must pay when you get these services
known as an outpatient level of care, which includes observation. If medical needs can be met at an outpatient level of care, you will remain in the hospital but the co-payment applied will be for outpatient services as defined in Chapter 4, Section 2.1. Collaborative discussion will occur between the medical staff at the hospital and the medical staff at Independent Health to determine the level of care most appropriate for your medical needs. Independent Health performs a process known as utilization review to determine the appropriate level of care for your identified needs based on the information provided by the attending physician. This review may occur concurrently (within 12-24 hours) or retrospectively (more than 24 hours, at times it may occur post discharge). Once the appropriate level of care is determined based on all of the clinical documentation referencing care you are receiving or have received, the co-payment will be determined as inpatient or outpatient. This co-payment will be referenced on your monthly EOB (Explanation of Benefits) statement provided to you by Independent Health. If the assessment findings of the attending physician indicate that there are no immediate medical needs requiring skilled care, but does identify that your personal safety may be at risk, the facility will work with you and your family to identify the most appropriate care and services to maintain your well-being. This may include homecare services, community services, or, identification of long-term care placement in some cases. Custodial care is excluded from Medicare coverage. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is	

Services that are covered for you	What you must pay when you get these services
receiving custodial care, the intermediary or carrier considers the level of care and medical supervision required and furnished. It does not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential. Independent Health will not authorize care and services that are considered custodial. If you, or your family, believe that you should remain at the hospital due to personal safety reasons, you have the right to request a review through the QIO. See Chapter 7. Section 6 for instructions on how to do that. If it is deemed your discharge is appropriate and you choose to remain at the hospital, the facility has the right to bill you in full for any charges incurred.	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay The plan covers up to 100 days per benefit period for skilled nursing care. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	**(Requires provider preauthorization.)** You are responsible for 100% of the costs after 100 days as a SNF patient per benefit period.
• Physician services	$0 copayment for physician services by a Hospitalist $10 copayment for physician services by a Specialty Physician
• Lab test (inpatient)	$0 copayment for each Medicare-covered lab test. 20% coinsurance for molecular or predisposition genetic testing.
• Diagnostic tests, such as: Electromyogram (EMG) Cardiovascular Stress Tests (See Advanced	$0 copayment for each diagnostic test from a Primary Care Physician

Services that are covered for you	What you must pay when you get these services
Radiology for Nuclear Stress Tests) Echocardiograms EKG	$10 copayment for each diagnostic test from a Specialty Physician
• X-rays	$25 copayment for each Medicare-covered x-ray **
• Advanced Radiology Diagnostic Services (Like CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imagine and PET scans)	$50 copayment for each Medicare-covered Advanced Radiology Diagnostic Services ** **Both copayments will apply for a diagnostic x-ray and an advanced radiology service if both are billed on the same day by the same provider.
• Radiation Therapy: radium, and isotope therapy including technician materials and services	20% coinsurance for Medicare-covered Radiation Therapy
• Surgical dressings	$0 copayment for each Medicare-covered surgical dressing item.
• Splints, casts and other devices used to reduce fractures and dislocations	$0 copayment for each Medicare-covered item to treat 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	$0 copayment for each internal Medicare-covered internal prosthetic or orthotic 20% coinsurance for each external Medicare-covered prosthetic or orthotic.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements	20% coinsurance for each Medicare-covered item

Services that are covered for you	What you must pay when you get these services
required because of breakage, wear, loss, or a change in the patient's physical condition	20% coinsurance for each Medicare-covered ostomy supply
• Physical therapy, speech therapy, and occupational therapy	$10 copayment for each Medicare-covered physical therapy, speech therapy, and occupational therapy treatment or evaluation treatment
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. This plan also offers supplemental medical nutrition therapy for all members regardless of diagnosis. We cover 4 interventions, for up to 3 hours each intervention (up to 12 hours annually) from a Credentialed Registered Dietician, PCP or Endocrinologist.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered or supplemental medical nutrition therapy services. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit. The MDPP program is a 2-year program Limit once per lifetime.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi ®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the	**(Certain services may require provider preauthorization)** 0% minimum coinsurance for each Medicare-covered Part B drug. 20% maximum coinsurance for each Medicare-covered Part B drug. Part B drugs may be subject to step therapy. If a Part B drug is administered in the office, home, or outpatient hospital setting, subject to 0% - 20% coinsurance in addition to the office/outpatient/home health agency member cost share for the administration of the drug. Insulin is subject to a coinsurance cap of $35 for one-month's supply of insulin.

Services that are covered for you	What you must pay when you get these services
drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv,® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions[plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of part B Drugs that may be subject to Step Therapy: www.independenthealth.com/IndividualsFamilies/Medicare Then click on "Formularies and Pharmacies". We also cover some vaccines under our Part B prescription drug benefit.	

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$40 copayment per visit for Medicare-covered Opioid Treatment Program services If a Part B drug is administered in the office: 0% - 20% coinsurance in addition to the office copay for the administration of the drug. This plan does NOT cover Part D drugs.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Advanced Radiology Services (Like CT Scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET Scans.)	**(Certain services require provider preauthorization)** $25 copayment for each Medicare-covered test** (If x-ray services are performed in the provider's office during an office visit, the appropriate office visit copayment and x-ray copayment will apply) $50 copayment for each Medicare-covered service** (**If advanced radiology services are performed in the provider's office during an office visit, the

Services that are covered for you	What you must pay when you get these services
	appropriate office visit copayment and advanced radiology service copayment will apply) **Both copayments will apply for a diagnostic x-ray and an advanced radiology service if both are billed on the same day by the same provider.
• Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for each Medicare-covered service** (If outpatient radiation therapy services are performed in the provider's office during an office visit, the appropriate office visit copayment and outpatient radiation therapy copayment will apply.)
• Surgical supplies, such as dressings	$0 copayment for each Medicare-covered surgical supply.
• Splints, casts and other devices used to reduce fractures and dislocations	$0 copayment for Medicare-covered splints and casts.
• Laboratory tests (outpatient)	$0 copayment for each Medicare-covered lab test. 20% coinsurance for molecular or predisposition genetic testing.
• 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.	$0 copayment for blood. Transfusion requires outpatient hospital copayment or office visit copayment.
• Other outpatient diagnostic tests such as: Electromyogram (EMG) Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests) Echocardiograms EKG	$0 copayment for Primary Care Physician for other Medicare-covered outpatient diagnostic tests. $10 copayment for Specialty Physician for other Medicare-covered outpatient diagnostic tests.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$150 copayment per visit for Medicare-covered outpatient hospital observation services.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Observation services	**(Provider preauthorization may apply for some services except for services in an emergency department)** $150 copayment per observation service. If Emergency Room and Observation Facility are billed on same day the Observation copay will be taken (See outpatient hospital).

Services that are covered for you	What you must pay when you get these services
• Services in an outpatient clinic	$0 copayment for Primary Care Physician services in an outpatient clinic. $10 copayment for Specialty Physician services in an outpatient clinic.
• Same day outpatient surgery (Includes diagnostic "scopes" such as an endoscopy)	$100 copayment for same-day outpatient surgery in a freestanding Ambulatory Surgical Center. $100 copayment for same-day outpatient surgery in an Outpatient Hospital Facility. To determine if the location is a freestanding ambulatory surgical center or an outpatient hospital facility, see the Physician/Provider Directory.
• Laboratory tests (outpatient)	$0 copayment for Medicare-covered lab tests. 20% coinsurance for molecular and predisposed genetic testing
• Diagnostic tests billed by the hospital, such as: Electromyogram (EMG) Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests) Echocardiograms EKG	$0 copayment for diagnostic tests from a Primary Care Physician $10 copayment for diagnostic tests from a Specialty Physician
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	$20 copayment per outpatient mental health visit With a diagnosis of depression, your first visit with a mental health provider is $0 copayment. $20 copayment for each partial hospitalization visit

Services that are covered for you	What you must pay when you get these services
• X-rays	$25 copayment for each Medicare-covered x-ray**
• Advanced Radiology Services (Like CT Scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET Scans.)	$50 copayment for each Medicare-covered advanced radiology service** **Both copayments will apply for a diagnostic x-ray and an advanced radiology service if both are billed on the same day by the same provider.
• Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for each Medicare-covered radiation therapy.
• Medical supplies such as splints and casts	$0 copayment for Medicare-covered supplies
• Certain screenings and preventive services	$0 copayment if listed as a preventive screening
• Certain drugs and biologicals that you can't give yourself	0% - 20% coinsurance If a Part B drug is administered in the office, home, or outpatient hospital setting, subject to 0% - 20% coinsurance in addition to the office visit or outpatient cost share for the administration of the drug.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-	

Services that are covered for you	What you must pay when you get these services
877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$20 copayment for Medicare-covered outpatient mental health services.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$10 copayment for each Medicare-covered outpatient rehabilitation service, treatment or evaluation.
Outpatient substance use disorder services Outpatient medical treatment for alcohol abuse, chemical abuse and chemical dependency.	$40 copayment for Medicare-covered outpatient substance abuse services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an *outpatient*.	**(Certain procedures may require provider preauthorization)** $100 copayment for freestanding Ambulatory Surgical Center $100 copayment for Outpatient Hospital Facility $0 copayment for certain joint replacements through Excelsior Orthopedic. To determine if the location is a freestanding ambulatory surgical center or an outpatient hospital facility, see the Physician/Provider Directory.

Services that are covered for you	What you must pay when you get these services
Over-the-counter (OTC) drugs and supplies Coverage for select over-the-counter items with NationsOTC. Your Independent Health plan offers a quarterly allowance that can be used to purchase select OTC items through the NationsOTC catalog. Visit www.nationsotc.com/IndependentHealth to view the catalog, or call 877-270-4239 (TTY: 711) 24 hours a day 7 days a week to request a copy. Orders can be placed by mail using the order form in the catalog, by telephone or online. This benefit can only be used for covered items through NationsOTC.	$100 allowance every three months. Allowance is made available by quarter (January 1st, April 1st, July 1st, October 1st). Allowance carries over quarter to quarter, but not plan year to plan year. Costs over the quarterly allowance are the member's responsibility.
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	$40 copayment per visit for Medicare-covered services
Personal Emergency Response Service (PERS) Personal Emergency Response Service (PERS) provided through NationsResponse. Members will have access to emergency alert devices, two-way connectivity to round-the-clock monitoring centers, and scheduled wellness checks. Members will have	$0 copayment for PERS through NationsResponse. Not covered if received through another vendor.

Services that are covered for you	What you must pay when you get these services
the "At Home" and "On the Go" PERS units to choose from. Member can order via phone by calling a NationsResponse Member Experience Advisor at (877) 270-4239 (TTY: 711), Monday – Friday, 8 a.m. – 8 p.m.	
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office	$0 copayment for Primary Care Physician $10 copayment for Specialty Physician
• Medically-necessary medical care or surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location	$100 copayment for Freestanding Ambulatory Surgical Center $100 copayment for Outpatient Hospital Facility
• Consultation, diagnosis, and treatment by a specialist	$10 copayment for Specialty Physician.
• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment	$0 copayment for Primary Care $10 copayment for Specialty Physician.
• Telehealth- Additional Telehealth Services Certain telehealth services, including: Primary Care, Specialty Physician, Outpatient mental health, outpatient substance abuse, urgent care, physical therapy, occupational therapy, speech therapy, kidney disease education, and diabetic self-management training. You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth. Contact your Provider(s) to see if they participate in telehealth services.	$0 copayment for telehealth visit with a Primary Care Physician $10 copayment for a telehealth visit with a Specialty Physician. $20 copayment for a telehealth visit with a mental health professional. $10 copayment for a telehealth visit for Physical Therapy, Speech Therapy, or Occupational Therapy. $55 copayment for a telehealth visit for urgent care.
• Certain telehealth services including consultation, diagnosis, and treatment by a	

Services that are covered for you	What you must pay when you get these services
physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	$10 copayment for a certain telehealth services with a Specialty Physician

Services that are covered for you	What you must pay when you get these services
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient	
• Second opinion by another network provider prior to surgery	$10 copayment for a second opinion by a Specialty Physician
• 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). Accidental injury to sound and natural teeth is not covered. Examples of non-covered services include: o The cost to repair or replace teeth (natural or dentures) o The cost to prepare the jaw for dentures, even if dentures are required because of a covered loss such as tumor removal or accidental trauma. o Exceptions: Medicare-covered dental services that are an integral part of a covered medical procedure. **This is NOT routine/preventive dental. (See Dental Care)**	$0 copayment if emergent dental care is provided in a Primary Care Physician's office. $10 copayment if emergent dental care provided in a Specialty Physician's office. $125 copayment facility copayment if emergent dental care provided in an emergency room setting. $100 copayment if emergent dental care provided in an outpatient freestanding ambulatory surgical center facility. $100 copayment if emergent dental care provided in an outpatient hospital facility.

Services that are covered for you	What you must pay when you get these services
• Home physician visits	$0 copayment for Primary Care Physician home visit. $10 copayment for Specialty Physician home visit.
• Additional Telemedicine Program - Teladoc® Benefit limited to Teladoc® Providers. Teladoc provides telephone and online internet consultations between members and Teladoc Providers for medical conditions that are not an Emergency Condition. Independent Health's telemedicine service provides coverage within the United States and anywhere world-wide where there is internet access. Independent Health's telemedicine benefit should not be used if a member is experiencing a medical emergency. The service is intended to provide a solution for non-emergency medical situations. The service is not intended to replace the primary care physician/patient relationship but rather offer members an alternative option to an urgent care facility or when a member is unable to obtain services from their primary care physician for many common medical issues including but not limited to: • Cold and Flu Symptoms • Bronchitis • Allergies • Poison Ivy • Eye Infection/Pink Eye • Urinary Tract Infection • Respiratory Infection • Strep Throat • Sinus Problems • Behavioral Health **Consultation Access:** There are three ways to register or set up a consultation: 1. Visit the Teladoc website at www.teledoc.com/mobile, and provide the required information along with your medical history.	$0 copayment for behavioral health services with a Teladoc provider. $25 copayment for other services with a Teladoc® provider. Not covered outside of the United States. Telemedicine services rendered through a provider other than a Teladoc provider are not covered. The service is available 24 hours a day, 7 days a week and may be accessed if traveling throughout the United States You are responsible for 100% of the total cost of any prescription prescribed by the Teledoc provider because this plan does NOT include Part D drugs.

Services that are covered for you	What you must pay when you get these services
2. Download the mobile app at Teladoc.com/mobile. 3. Call Teladoc at 1-800-Teladoc (1-800-835-2362) to create an account. TTY users call 1-800-877-8973. Telephone service is only available within the United States. We also offer Teladoc via a smart phone or tablet app anywhere in the world where there is internet access. Download the app from www.teladoc.com/ih to your smart phone or tablet, create your account and you'll have access to a doctor from your home state from most places in the world, including on cruise ships, within 60 minutes. If you have already created your account, you can access Global Care through it. If it is appropriate for your health condition, a prescription recommendation will be sent to you that you can take to a pharmacy. There is a CMS regulation that prohibits Independent Health or Medicare from covering the cost of any Part D. prescription drug when it's purchased outside of the United States or it's territories. Account creation involves completing baseline health information such as providing a medical history, allergy information, list of medications, health problems, family history and Primary Care Physician contact information. If necessary, the doctor may prescribe medication for your diagnosis. Prescriptions for short-term antibiotics, antihistamines or anti-bacterial agents can be sent to your preferred pharmacy. Nearly all of the drugs prescribed are generic. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse.	
Podiatry services	$10 copayment in a Specialty Physician's office

Services that are covered for you	What you must pay when you get these services
Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. Limit once every 60 days.	$100 copayment facility copayment in a freestanding Ambulatory Surgical Center. $100 copayment in an Outpatient Hospital Facility. To determine if the location is a freestanding ambulatory surgical center or an outpatient hospital facility, see the Physician/Provider Directory.
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. Separate office visit cost sharing will apply if prostate screening is performed separate from the "Annual Wellness Visit" exam: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
Prosthetic and orthotic devices and related supplies	20% coinsurance for each external Medicare-covered standard prosthetic device and related supplies.

Services that are covered for you	What you must pay when you get these services
Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	$0 copayment for related supplies. 20% coinsurance for Medicare-covered ostomy supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0 copayment for Medicare-covered pulmonary rehabilitation services. Limit 36 visits per cardiac occurrence.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office

Services that are covered for you	What you must pay when you get these services
place in a primary care setting, such as a doctor's office.	$10 copayment in a Specialty Physician's office
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$0 copayment for Medicare-covered services for kidney disease education However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	20% coinsurance per outpatient dialysis treatment
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) See inpatient hospital for cost share.	**For inpatient dialysis treatments, see Inpatient Hospital Care cost share.**
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare covered services for self-dialysis training.
• Home dialysis equipment and supplies	20% coinsurance for home dialysis equipment

Services that are covered for you	What you must pay when you get these services
• 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**.	\$0 copayment for home dialysis supplies. \$0 copayment for certain home support services.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered up to 100 days per benefit period for skilled services only (includes subacute admissions in a skilled nursing facility.) No prior hospital stay is required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. 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	**(Requires provider preauthorization)** For Days 1 through 20: \$0 copayment per day. For Days 21 through 100: \$214 copayment per day. No coverage for days 1 and beyond for each stay. Covered up to 100 days per benefit period. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Copayment is not waived when member is discharged from acute hospital and admitted to a SNF. This includes SNF to SNF. You are responsible for the maximum number of per day cost

Services that are covered for you	What you must pay when you get these services
• X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse or domestic partner is living at the time you leave the hospital.	shares for each benefit period. If you are discharged from the skilled nursing facility prior to using the maximum number of per day cost shares, and you are readmitted during the benefit period, you will be responsible for the remaining number of per day cost shares. You will not be responsible for more than the maximum number of per day cost shares per benefit period.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. if you do not have signs or symptoms of tobacco-related disease. However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: $0 copayment in a Primary Care Physician's office $10 copayment in a Specialty Physician's office $0 copaymentfor cessation counseling and treatment in a Primary Care Physician's office if you have been diagnosed with a tobacco related disease or are

Services that are covered for you	What you must pay when you get these services
will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	taking medicine that may be affected by tobacco. $10 copayment for cessation counseling and treatment in a Specialty Physician's office if you have been diagnosed with a tobacco related disease or are taking medicine that may be affected by tobacco.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$25 copayment per session for Medicare-covered supervised exercise therapy.

Services that are covered for you	What you must pay when you get these services
Transportation Non-emergency transportation to plan-approved locations such as to a doctor's office visit, pharmacies and dialysis centers. Independent Health coordinates rides that are appropriate for your health needs. Schedule rides at least 3 days in advance. When a member needs to cancel a ride that they previously scheduled, they need to cancel the ride at least 2 hours ahead of the scheduled pick up time or the member will be charged one of their trips from their annual allotment This benefit is not to be used for emergency situations. For Emergency transportation: See Ambulance.	$0 copayment for up to 24 one-way trips to an Independent Health network approved location. 30-mile limit applies per trip. Your ride must originate in the 8 counties of Western New York. Rides must be coordinated through Independent Health's transportation coordinator. Call SafeRide at 855-932-5420 (TTY 711) Monday – Sunday 8:00 a.m. – 8:00 p.m. or contact Independent Health Member Services.
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.	$55 copayment for Medicare-covered urgently needed care services. Urgent care is available at urgent care centers and/or walk-in clinics. **Outside United States and its territories:** Worldwide coverage: Maximum plan benefit limit of $10,000. The $10,000 plan limit is per occurrence for the unforeseen event outside of the USA. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share.
 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover	**Medical Vision:** $10 copayment for Medicare-covered medical eye exam.

Services that are covered for you	What you must pay when you get these services
routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. • 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.)	$0 copayment for glaucoma screening as part of a routine eye exam from an EyeMed provider. Like Original Medicare, only standard frames and lenses from an EyeMed Provider are covered in full after each Post Cataract surgery. $0 copayment for pair of conventional contact lenses. Conventional contact lenses (in lieu of frames and lenses) include fit, follow-up and materials from an EyeMed provider. The member will be responsible for $0 copayment for standard, non-vision correcting lenses during cataract surgery. The member will be responsible for any additional costs for lenses which correct your vision and replace your need to wear glasses. Frequency: Once per eye per surgery. Member cannot combine any promotional offers with our vision benefit.
• For people with diabetes, screening for diabetic retinopathy is covered once per year.	$0 copayment for screening for diabetic retinopathy. Retinal imaging to diagnose other injury or disease of the eye will have an office visit copay as outlined below.
Supplemental Vision • **Routine vision exam** Routine Eye Exam with dilation from an EyeMed Provider (one exam every 12 months). Glaucoma screening every 12 months (for high-risk individuals, individuals with family history of glaucoma, individuals with diabetes and African Americans who are age 50 and older).	$0 copayment for routine vision exam from an EyeMed Provider

Services that are covered for you	What you must pay when you get these services
• **Routine Eye Wear** Such as glasses (lenses and frames) or contact lenses in lieu of glasses	Limit: One routine eye exam every twelve months from an EyeMed provider. Member cannot combine any promotional offers with our vision benefit. $200 limit for eyewear every year from an EyeMed Provider. Member cannot combine any promotional offers with our vision benefit.
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. For other services performed in conjunction with the office visit, please see specific service for cost share.

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are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality.

Below is a list of DME items that are covered at a reduced cost share when purchased through People First Mobility.

Code	*Description*
E0100	Cane, any material, adjustable or fixed height, with tip
E0105	Cane, 3 or 4 prong, any material, adjustable or fixed height, with tip
E0135	Walker, folding, adjustable or fixed height
E0149	Walker, heavy-duty, without wheels, rigid or folding, any type
E0154	Walker, platform attachment, each
E0156	Walker, seat attachment, each
E0165	Commode chair, mobile or stationary, detachable arms
E0185	Gel or gel-like pressure pad for mattress, standard mattress height & length
E0190	Positioning cushion/pillow/wedge, any size or shape, includes all accessories and components
E0303	Hospital bed, heavy-duty, extra wide, capacity greater than 350 lbs but less than 600 lbs.
E0445	Oximeter, noninvasive measuring device of blood oxygen levels
E0570	Nebulizer with compressor
E0621	Patient lift, sling or seat, canvas or nylon
E0627	Seat lift mechanism, electric, any type
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
E0635	Patient lift, electric, with seat or sling
E0651	Pneumatic compressor, segmental home model, without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model, with calibrated gradient pressure
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0776	Intravenous (IV) pole
E0910	Trapeze bars, (aka: Patient Helper), attached to bed, with grab bars
E0940	Trapeze bars, freestanding, complete with grab bar
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each
E0971	Manual wheelchair accessory, anti-tipping device, each
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each
E0978	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each
E0981	Wheelchair accessory, seat upholstery, replacement only, each
E0982	Wheelchair accessory, back upholstery, replacement only, each
E0986	Manual wheelchair accessory, push-rim activated power assist system
E0990	Wheelchair accessory, elevated legrest, complete assembly, each

Code	*Description*
E1007	Wheelchair accessory, power seating system, combination tilt & recline, with mechanical sheer reduction
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete assembly, any type, each
E1028	Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1161	Manual adult size wheelchair, includes tilt in space
E1225	Wheelchair accessory, manual, semi-reclining back (15 - 80 degrees), each
E1226	Wheelchair accessory, manual, fully reclining back (80 degrees or more) each
E1230	Power operated vehicle, 3 or 4 wheel non-highway
E2201	Manual wheelchair accessory, nonstandard seat frame, width greater than 20 inches but less than 24 inches
E2209	Accessory, arm trough, with or without hand support, each
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat) includes any type of mounting hardware
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator features, mechanical function selection switch, and fixed mounting hardware
E2313	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g.: gel cell, absorbed glassmat
E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick, (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware
E2378	Power wheelchair component, actuator, replacement only
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width is less than 22 inches, any height, including any type of mounting hardware.
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
K0002	Standard hemi (low-seat) wheelchair
K0004	High strength, lightweight wheelchair
K0007	Extra heavy duty wheelchair
K0019	Arm pad, replacement only, each
K0040	Adjustable angle footplate, each

Code	*Description*
K0108	Wheelchair component or accessory not otherwise specified
K0195	Elevating wheelchair leg rests, pair
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, capacity to 300 lbs
K0823	Power wheelchair, group 2 standard, captain's chair, capacity to 300 lbs
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, capacity 301 to 450 lbs.
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, capacity up to 300 lbs.
L3908	Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off the shelf.

SECTION 3 What services are not covered by the plan?

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		• Limited Coverage. See Home Delivered Meals
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered. • Certain Evaluation and Management services are covered. See Chiropractic Services in the Chapter 4 Benefit Chart and the List of Excluded Services below.
Routine dental care, such as cleanings, fillings or dentures.		Limited coverage through LIBERTY Dental Plan. See "Dental Services" on the medical benefit chart in Chapter 4 for covered services.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Routine eye exam and eyewear: Limited coverage through EyeMed. See "Supplemental Vision" on the medical benefits chart in Chapter 4 for covered services.
Routine foot care		• Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		Hearing aid evaluation exam and Hearing aids/fitting: Limited coverage through Start Hearing, Inc. network. See "Hearing Services" on the medical benefits chart in Chapter 4 for covered services.
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	

In addition, the following items and services aren't covered by your Independent Health Medicare Advantage plan:

- Services that are not covered under Original Medicare, unless such services are specifically listed as covered in Chapter 4.
- Services that you get from non-affiliated providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, and care from non-affiliated providers that is arranged or approved by Independent Health's Medical Director.
- Services that you get without prior authorization, when prior authorization is required for getting that service (Chapter 4 gives a definition of prior authorization and tells which services require prior authorization by your provider.)
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Independent Health or Original Medicare.
- Any services related to your terminal condition provided to you when you enroll in a Medicare-certified hospice are not covered by Independent Health, but are reimbursed directly by Original Medicare except for supplemental benefits which are not covered by Original Medicare.
- Cloning or any service incident to cloning.
- Emergency facility services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition.
- Dental splints, dental prostheses, dentures, dental implants or any dental treatment for teeth, gums, or jaw, periodontal cleanings, and dental treatment related to Temporomandibular Disorders (TMD). (Please see dental benefits, limitations and exclusions under the dental benefit below.)
- Services required by a third party. Examples of non-covered services are physical examinations that are not medically necessary, such as those required by employment, insurance, licensing, marriage, and court-ordered examinations.
- Benefits provided for any loss for which mandatory automobile no fault benefits are recovered or recoverable including benefits which would have been recoverable except for the fact that a timely claim was not filed by the Member or by a health care provider.
- Services provided after your membership in Independent Health's Encompass 65 (HMO) ends, except in some cases hospital care if you are an inpatient in the hospital receiving acute care services on the day your coverage ends.
- Outpatient prescription drugs that don't meet the definition of a Part D drug as defined by CMS, or as listed in Chapter 4, or in the Independent Health's Prescription Drug Formulary.
- Non-emergent transportation such as wheelchair van, taxi, stretcher van or ambulette ambulette not scheduled through SafeRide.

- Coverage for accommodating intraocular lenses and related services (lenses which correct your vision and replace your need to wear glasses), except for that portion of the hospital outpatient or physician charges equal to the charge for insertion of a conventional intraocular lens (standard, non-vision correcting lenses).
- Excluded Durable Medical Equipment (DME) and personal care items include but are not limited to:
    - Incontinent Pads, disposable underpads, diapers, briefs, and liners.
    - Automated blood pressure cuff.
    - Over the Counter items
    - Personal alarms and/or emergency response systems, including associated fees.
    - Items such as tub stools or benches, raised toilet seats, toilet rails, bathtub wall rails, bath/shower chairs, and seat lift mechanisms placed over the top of a toilet.
    - Over the tub whirlpools
    - Exercise equipment
    - Therapeutic light boxes
    - Home modifications and associated fees.
- Contraceptive devices and insertion and removal of contraceptive devices are not covered (such as an IUD).
- Services provided by a physician or other practitioner who has been precluded by Medicare, except for emergency and urgently needed services.
- With limited exceptions, services provided by an individual who has been sanctioned by CMS or has formally been precluded from the Medicare Program.
- Durable Medical Equipment coverage for items/devices that are not appropriate for use in the member's home environment. Please see Chapter 10 for definition of 'Member's Home'.

  For a nursing home enrollee who is custodial, all types of the following DME are not covered: Group 1 pressure support as routine, oxygen, nebulizer machines, gel pads for wheel chair use, all standard hospital beds, excluding heavy duty and other, Standard wheelchairs without accessories, Front wheeled, four-wheeled, and standard walkers, commode seats, and other similar DME that any custodial nursing home resident routinely requires for non-skilled daily care.
- Compression stockings, with the exception of these codes A6552, A6554, A6583, A6531, A6532, A6534, A6535, and A6545 are limited to 6 pairs (12 individual stockings) per year cumulative total. Additionally, we match Original Medicare to cover compression garments to treat lymphedema.
- Post Mastectomy Bras: Limited to 4 per year

- Electric Hospital Beds: A fully electric bed and accessories and parts are not covered. This is an electric bed that has a height adjustment feature as well as electric head and foot adjustment mechanism.
- Oscillating, circulating, and Stryker frame hospital beds.
- Hospital bed accessory; board, table, or support device, any type.
- Independent Health does not transfer ownership of durable medical equipment items to the member, such as but not limited to oxygen equipment and vents, hospital grade breast pumps and wearable defibrillators.
- Routine Foot Care is not covered except for members with certain medical conditions affecting the lower limbs. Our coverage for routine foot care matches Original Medicare.
- Chiropractic services other than the manual subluxation of the spine are not covered with the exception of the following Evaluation and management codes: 99202, 99203, 99204, 99211, 99212, 99213. This includes but is not limited to office visits, and radiological services.
- We do not cover services or programs related to, or as part of, Adult Day Care.
- We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).
- The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.
- Dialysis outside of the United States.

LIBERTY Dental Plan Dental Plan Exclusions:

The following dental services are excluded under the plan:

- Any service that is not specifically listed as a covered benefit in this booklet.
- Any service listed as a covered benefit in this booklet that has met the frequency limitations.
- Any service provided by a dentist excluded from participating in a federal health care program, such as Medicare and/or Medicaid.
- Services performed after the Plan Benefit Maximum has been met.

You pay 100% for services not listed in this chart. The following codes are covered under your Comprehensive Dental benefit with a LIBERTY Dental Plan provider. Certain criteria and provider preauthorization may be required:

CDT Code	Description	Member Responsibility	Limitations
	Diagnostic Services		
D0120	Periodic oral evaluation	0%	2 of (D0120-D0180) every calendar year
D0140	Limited oral evaluation	0%	
D0150	Comprehensive oral evaluation	0%	
D0160	Oral evaluation, problem focused	0%	
D0170	Re-evaluation, limited, problem focused	0%	
D0171	Re-evaluation, post operative office visit	0%	
D0180	Comprehensive periodontal evaluation	0%	
D0210	Intraoral, comprehensive series of radiographic images	0%	1 of (D0210, D0330) every 3 calendar years
D0220	Intraoral, periapical, first radiographic image	0%	
D0230	Intraoral, periapical, each add 'l radiographic image	0%	
D0240	Intraoral, occlusal radiographic image	0%	2 (D0240) every calendar year
D0270	Bitewing, single radiographic image	0%	2 of (D0270-D0274) every calendar year
D0272	Bitewings, two radiographic images	0%	
D0273	Bitewings, three radiographic images	0%	
D0274	Bitewings, four radiographic images	0%	
D0277	Vertical bitewings, 7 to 8 radiographic images	0%	1 (D0277) every 3 calendar years
D0330	Panoramic radiographic image	0%	1 of (D0210, D0330) every 3 calendar years
	Preventive Services		

CDT Code	Description	Member Responsibility	Limitations
D1110	Prophylaxis, adult	0%	2 of (D1110, D4346, D4910) every calendar year
D1206	Topical application of fluoride varnish	0%	2 (D1206) every calendar year
D1208	Topical application of fluoride, excluding varnish	0%	1 (D1208) every calendar year
	Restorative Services		
D2140	Amalgam, one surface, primary or permanent	50%	1 of (D2140-D2335, D2391-D2394) every 3 calendar years per surface per tooth
D2150	Amalgam, two surfaces, primary or permanent	50%	
D2160	Amalgam, three surfaces, primary or permanent	50%	
D2161	Amalgam, four or more surfaces, primary or permanent	50%	
D2330	Resin-based composite, one surface, anterior	50%	
D2331	Resin-based composite, two surfaces, anterior	50%	
D2332	Resin-based composite, three surfaces, anterior	50%	
D2335	Resin-based composite, four or more surfaces	50%	
D2390	Resin-based composite crown, anterior	50%	1 (D2390) every 3 calendar years per tooth
D2391	Resin-based composite, one surface, posterior	50%	1 of (D2140-D2335, D2391-D2394) every 3 calendar years per surface per tooth
D2392	Resin-based composite, two surfaces, posterior	50%	
D2393	Resin-based composite, three surfaces, posterior	50%	

CDT Code	Description	Member Responsibility	Limitations
D2394	Resin-based composite, four or more surfaces, posterior	50%	
D2710	Crown, resin-based composite (indirect)	50%	1 of (D2710-D2794) every 5 calendar years per tooth
D2712	Crown, ¾ resin-based composite (indirect)	50%	
D2720	Crown, resin with high noble metal	50%	
D2721	Crown, resin with predominantly base metal	50%	
D2722	Crown, resin with noble metal	50%	
D2740	Crown, porcelain/ceramic	50%	
D2750	Crown, porcelain fused to high noble metal	50%	
D2751	Crown, porcelain fused to predominantly base metal	50%	
D2752	Crown, porcelain fused to noble metal	50%	
D2780	Crown, ¾ cast high noble metal	50%	
D2781	Crown, ¾ cast predominantly base metal	50%	
D2782	Crown, ¾ cast noble metal	50%	
D2783	Crown, ¾ porcelain/ceramic	50%	
D2790	Crown, full cast high noble metal	50%	
D2791	Crown, full cast predominantly base metal	50%	
D2792	Crown, full cast noble metal	50%	
D2794	Crown, titanium and titanium alloys	50%	
D2952	Post and core in addition to crown, indirectly fabricated	50%	1 of (D2952, D2954) every 5 calendar years per tooth
D2953	Each additional indirectly fabricated post, same tooth	50%	1 (D2953) every 5 calendar years per tooth
D2954	Prefabricated post and core in addition to crown	50%	1 of (D2952, D2954) every 5 calendar years per tooth

CDT Code	Description	Member Responsibility	Limitations
	Endodontic Services		
D3221	Pulpal debridement, primary and permanent teeth	50%	1 (D3221) in a lifetime per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	50%	1 of (D3310-D3330) in a lifetime per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	50%	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	50%	
D3331	Treatment of root canal obstruction; non-surgical access	50%	1 (D3331) in a lifetime per tooth
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	50%	1 (D3332) in a lifetime per tooth
D3333	Internal root repair of perforation defects	50%	1 (D3333) in a lifetime per tooth
D3346	Retreatment of previous root canal therapy, anterior	50%	1 of (D3346-D3348) in a lifetime per tooth
D3347	Retreatment of previous root canal therapy, premolar	50%	
D3348	Retreatment of previous root canal therapy, molar	50%	
	Periodontal Services		
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	50%	1 of (D4341, D4342)every 2 calendar years per site/per quadrant, no more than 2 quads allowed per date of service
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	50%	
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	50%	2 of (D1110, D4346, D4910) every calendar year

CDT Code	Description	Member Responsibility	Limitations
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	50%	1 (D4355) every 3 calendar years
D4910	Periodontal maintenance	50%	2 of (D1110, D4346, D4910) every calendar year
	Removable Prosthodontics Services		
D5110	Complete denture, maxillary	50%	1 of (D5110-D5283) every 5 calendar years per arch
D5120	Complete denture, mandibular	50%	
D5130	Immediate denture, maxillary	50%	
D5140	Immediate denture, mandibular	50%	
D5211	Maxillary partial denture, resin base	50%	
D5212	Mandibular partial denture, resin base	50%	
D5213	Maxillary partial denture, cast metal, resin base	50%	
D5214	Mandibular partial denture, cast metal, resin base	50%	
D5221	Immediate maxillary partial denture, resin base	50%	
D5222	Immediate mandibular partial denture, resin base	50%	
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	50%	
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	50%	
D5225	Maxillary partial denture, flexible base	50%	
D5226	Mandibular partial denture, flexible base	50%	
D5282	Removable unilateral partial denture, one piece cast metal, maxillary	50%	

CDT Code	Description	Member Responsibility	Limitations
D5283	Removable unilateral partial denture, one piece cast metal, mandibular	50%	
D5410	Adjust complete denture, maxillary	50%	1 of (D5410-D5422) every calendar year per arch
D5411	Adjust complete denture, mandibular	50%	
D5421	Adjust partial denture, maxillary	50%	
D5422	Adjust partial denture, mandibular	50%	
D5511	Repair broken complete denture base, mandibular	50%	1 of (D5511, D5512) every calendar year per arch
D5512	Repair broken complete denture base, maxillary	50%	
D5520	Replace missing or broken teeth, complete denture	50%	1 (D5520) every calendar year per arch
D5611	Repair resin partial denture base, mandibular	50%	1 of (D5611-D5622) every calendar year per arch
D5612	Repair resin partial denture base, maxillary	50%	
D5621	Repair cast partial framework, mandibular	50%	
D5622	Repair cast partial framework, maxillary	50%	
D5630	Repair or replace broken retentive clasping materials, per tooth	50%	1 (D5630) every calendar year per tooth
D5640	Replace broken teeth, per tooth	50%	1 (D5640) every calendar year per tooth
D5650	Add tooth to existing partial denture	50%	1 (D5650) every calendar year per tooth
D5660	Add clasp to existing partial denture, per tooth	50%	1 (D5660) every calendar year per tooth
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	50%	1 of (D5670, D5671) every 2 calendar years per arch

CDT Code	Description	Member Responsibility	Limitations
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	50%	
D5710	Rebase complete maxillary denture	50%	1 of (D5710-D5761) every 2 calendar years per arch
D5711	Rebase complete mandibular denture	50%	
D5720	Rebase maxillary partial denture	50%	
D5721	Rebase mandibular partial denture	50%	
D5730	Reline complete maxillary denture, direct	50%	
D5731	Reline complete mandibular denture, direct	50%	
D5740	Reline maxillary partial denture, direct	50%	
D5741	Reline mandibular partial denture, direct	50%	
D5750	Reline complete maxillary denture, indirect	50%	
D5751	Reline complete mandibular denture, indirect	50%	
D5760	Reline maxillary partial denture, indirect	50%	
D5761	Reline mandibular partial denture, indirect	50%	
	Oral & Maxillofacial Services		
D7140	Extraction, erupted tooth or exposed root	50%	1 of (D7140-D7250) per lifetime per tooth
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	50%	
D7220	Removal of impacted tooth, soft tissue	50%	
D7230	Removal of impacted tooth, partially bony	50%	
D7240	Removal of impacted tooth, completely bony	50%	
D7241	Removal impacted tooth, complete bony, complication	50%	

CDT Code	Description	Member Responsibility	Limitations
D7250	Removal of residual tooth roots (cutting procedure)	50%	
D7260	Oroantral fistula closure	50%	1 (D7260) every 5 calendar years per site/quad
	Adjunctive General Services		
D9110	Palliative treatment of dental pain, per visit	50%	1 (D9110) every calendar year
D9310	Consultation, other than requesting dentist	50%	1 (D9310) every 6 months
D9311	Consultation with a medical health care professional	50%	
D9995	Teledentistry, synchronous; real-time encounter	0%	2 of (D9995, D9996) every calendar year
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	0%	

Start Heairng - Hearing Aid Exclusions:

The following hearing aid services are excluded under the plan:

- Hearing aids and provider visits to service hearing aids (except as specifically described in the covered benefits)
- Ear molds
- Hearing aid accessories
- Warranty claim fees and hearing aid batteries in excess of the 40 that come with the original purchase
- Costs associated with replacing lost or damaged hearing aids ($250 per hearing aid).
- Hearing aids other than select Starkey models purchased through an Start Hearing network provider.

CHAPTER 5:

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

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

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

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

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

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

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

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

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

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

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

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

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

3. If you are retroactively enrolled in our plan

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

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

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

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

Either download a copy of the form from our website (www.independenthealth.com/Portals/0/PDFs/Individuals/IndependentHealthGeneralClaimForm.pdf) or call Member Services and ask for the form.

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

Independent Health
PO Box 9066
Buffalo, NY 14231-9066
Attn: Claims Department

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

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

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

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

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

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

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

CHAPTER 6:
Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. Verbal translation of written materials is available via free interpreter services. For those with special needs, accessibility to benefit information or alternate formats (e.g., large print) of written materials is available upon request. 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.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please call to file a grievance with Independent Health Member Services at 1-800-501-3439. TTY users call 711. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to

network providers. If you do not choose a Primary Care Provider (PCP), one will be selected for you. You have the right to change your PCP at any time.

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us

to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

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

The Independent Health Quality Initiative
Quality Physicians

Independent Health's credentialing standards ensure you receive appropriate care from qualified physicians in appropriate settings. Our credentialing team checks the status of a physician's license, verifies that the physician has had the appropriate training for his or her specialty, and looks for any potential problems with the quality of care a physician provides his or her patients. This review takes place when a physician first joins the network, upon recredentialing every three years, and on an ongoing basis through the Credentialing program.

Continuous Improvement

At Independent Health, we value any comments and feedback that our members can provide. One of the ways we do this is by having one third of our board of directors comprised of Independent Health members. Their active participation in the creation and approval of policies implemented by Independent Health acts as a check and balance to what our members want, and don't want. You always have an opportunity to participate in developing Independent Health's policies or voice your concerns by calling our Member Services department at (716) 250-4401 or 1-800-665-1502. If you would like to receive a complete copy of Independent Health's Quality Management Program Description, please call our Member Services department at (716) 250-4401 or 1-800-665-1502 or TTY at 711. You may also view it online at www.independenthealth.com.

How we pay the doctors and other providers who take care of you

Independent Health pays its providers using various payment methods which may include fee-for-service, case rate, per diem, per member per month (PMPM), and incentive arrangements.

- Fee-For-Service means paying a provider a defined dollar amount per each service (like an office visit, procedure or test) rendered
- Per Diem means paying a provider a fixed dollar amount per day for services rendered
- Case Rate means paying a provider a fixed dollar amount that covers a defined group of procedures and services
- In addition to Independent Health's credentialing and utilization management policies to help ensure high quality care across all payment methodologies, incentive payments to providers more directly link reimbursement to the effectiveness and efficiency of the care delivered.

- Per Member Per Month (PMPM) means paying a fixed dollar amount to a provider each month for each member under that provider's care

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services that you might need. For more specific information, call Member Services at the number on the cover of this booklet.

Note that it is Independent Health's responsibility to pay providers for the covered benefits and services you receive (other than the copayments, coinsurance, or other payments that are your responsibility). This includes paying network providers (those that have agreed to provide services to Independent Health's Medicare Members), and paying non-network who have been authorized by us to provide services to you, or who provide covered emergency, post-emergency, urgently needed services, or out-of-area dialysis. In the event we fail to pay a provider for covered services or prior authorized services, you will not be liable for any further payment owed by Independent Health.

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

As a member of Independent Health's Encompass 65 (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

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

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

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

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

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

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

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

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

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive

forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with New York State Department of Health at 1-716-847-4532 or www.health.ny.gov.

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

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

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

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

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

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

  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your premium for your Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area for more than six months, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

You can also visit the Medicare website (www.medicare.gov).

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to

do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

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

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

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

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

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

- You **can call us at Member Services**.

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

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

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

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

Section 6 of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

Section 7 of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

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

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

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

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3**

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

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

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

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

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

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

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

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

For fast Coverage decisions, we use an expedited timeframe.

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

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

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

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

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

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

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

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

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

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

If you are asking for a standard appeal, submit your standard appeal in writing. You may also ask for an appeal by calling us. Chapter 2 has contact information.

If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.

You must make your appeal request within 65 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.

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

When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.

We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.

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

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a *fast complaint*. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

If our answer is yes to part or all of what you requested, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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

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

Step 1: The independent review organization reviews your appeal.

We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.

You have a right to give the independent review organization additional information to support your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

For the *fast appeal* the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

If the review organization says yes to part or all of a request for a medical item or service, we must authorize the medical care coverage within 72 hours or provide the service within 14

calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.

If the review organization says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests,** we have **24 hours** from the date we receive the decision from the review organization.

If this organization says no to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called *upholding the decision* or *turning down your appeal*). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

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

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

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

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.

- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

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

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

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

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

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

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

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

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

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:

    - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
    - Your right to be involved in any decisions about your hospital stay.
    - Where to report any concerns you have about quality of your hospital care.
    - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**

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

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

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

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

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

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

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

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

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

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the review organization says yes:

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

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

If the review organization says no:

It means they agree with the decision they made on your Level 1 appeal. This is called *upholding the decision*.

The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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

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

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

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

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

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

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

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

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

Follow the process.

Meet the deadlines.

Ask for help if you need it. If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

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

What happens during this review?

Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage,** from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**

You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

If the reviewers say *no*, then **your coverage will end on the date we have told you.**

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says yes?

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

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

What happens if the review organization says no?

It means they agree with the decision made to your Level 1 appeal.

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

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

There are three additional levels of appeal after Level 2, (for a total of five levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

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

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

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor Member Services, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know.

1-800-665-1502 or 716-250-4401
TTY users only: 711
Hours of operation (Eastern time):
October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.
April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.

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.

Filing a grievance with our Plan

- If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) in Section 9. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you.
- To initiate a written grievance, you may send a letter or complete a Member Complaint Form. The Member Complaint Form will be provided upon request from Member Services and can also be found on www.independenthealth.com. Written grievances may be sent by mail to Independent Health, attn: P.O. Box 2090, Buffalo, NY 14231-2090. A written grievance can also be sent to Independent Health by fax to the attention of Appeals and Complaints at (716-635-3504) or email to the attention of Appeals and Complaints at (Appeals@independenthealth.com)
- A verbal grievance is initiated by phoning the Member Services department at 716-250-4401 or 1-800-665-1502 (TTY: 711).

- The grievance must be filed within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we do not substantiate your grievance in whole or in part, our written decision will explain the reason behind our decision, and will tell you about any dispute resolution options you may have.

Option for Filing a "Fast Grievance"

You may request a "fast" grievance with Independent Health for any of the following reasons:

1. Independent Health chooses to extend the time frame to make an initial decision and you did not want that to happen;
2. Independent Health chooses to extend the time frame to make a decision regarding your appeal and you did not want that to happen;
3. Independent Health refuses to grant your request for a "fast" initial decision;
4. Independent Health refuses to grant your request for a "fast" appeal decision

How to file a "fast" grievance

- **Step 1:** As a member of Independent Health, you or your representative may make a verbal request for a "fast" grievance to a representative of the Member Services department. You may contact the Member Services department at 716-250-4401 or 1-800-665-1502, October 1 – March 31: Monday through Sunday, 8 a.m. – 8 p.m. and April 1 – September 30: Monday through Friday, 8 a.m. – 8 p.m. (TTY users only may call: 711) when outside the service area. The Member Services department will document your grievance and forward it to Independent Health's Appeals and Complaints Department. You may also send a fax to 716-635-3504 to the attention of Appeals and Complaints for a fast grievance request.

- **Step 2:** A review specialist in Appeals and Complaints will be assigned to investigate your "fast" grievance and provide you with a response within 24 hours.

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

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

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call.

Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar**

days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint. If you have a *fast complaint*, it means we will give you **an answer within 24 hours**.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

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

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

Or

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Independent Health's Encompass 65 (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Independent Health's Encompass 65 (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.

There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

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

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

Your membership will end in our plan when your new plan's coverage begins on January 1.

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

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

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the

month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.

- **During the annual Medicare Advantage Open Enrollment Period**, you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, youcan also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of Independent Health's Encompass 65 (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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

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

The enrollment time periods vary depending on your situation.

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

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

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

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

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

- **Call Member Services**.
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

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

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

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

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

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

SECTION 5 Independent Health's Encompass 65 (HMO) must end your membership in the plan in certain situations

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

Independent Health's Encompass 65 (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
  - If you have been a member of our plan continuously prior to January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

Independent Health's Encompass 65 (HMO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Miscellaneous Provisions

Benefits are personal to you and may not be assigned. Benefits under this Evidence of Coverage are available to you in accordance to the terms stated in this Evidence of Coverage. Neither Independent Health, nor IPA/WNY shall have any liability for any service received that was not

in accordance with the terms stated in this Evidence of Coverage. No liability may be imposed on Independent Health other than for the benefits specifically provided herein.

You give permission, by accepting this Evidence of Coverage, to Independent Health to obtain your medical records from any health care provider or institution to the extent permitted by law. You also agree that Independent Health may refer these medical records to health care providers or institutions that Independent Health deems appropriate.

In the event of any major disaster or epidemic, war, riot, labor dispute or other causes beyond Independent Health's control, Independent Health shall provide coverage hereunder, according to its best judgment, within the limitations of such facilities and personnel as are then available. Independent Health shall put forth its best effort to arrange for such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

The relationship between Independent Health and network providers and between Independent Health and hospital and SNF is an independent contractor relationship. No network provider, hospital or SNF, or any other institution, is an employee or agent of Independent Health. Independent Health or any employee of Independent Health is not an employee or agent of any network provider, hospital or SNF, or other institutions.

Independent Health's Plan membership cards are for identification only. Possession of an Independent Health's Plan membership card confers no right to services or benefits under this Evidence of Coverage. You must be enrolled in our Plan to be entitled to the services and benefits covered in this Evidence of Coverage.

SECTION 5 Independent Health's Right to Recover Expenses Paid for by Third Parties and Right of Subrogation

You understand and agree to the following provisions regarding Independent Health's right to recovery of paid expenses and right of subrogation.

1. When you receive reimbursement for hospital, medical, and/or health care expenses as a result of court action, judgment, settlement or payments from liability coverage of any party and/or any other reimbursement method, then you shall reimburse Independent Health for such expenses that Independent Health pays on your behalf; and Independent Health shall have a lien upon such judgment, settlement, payment or other reimbursement to the extent Independent Health has paid your expenses, in accordance with Section 42 of the Code of Federal Regulations ("CFR") 422.108.
2. At its discretion, Independent Health may also authorize a provider to bill you or any other party liable for your injury, illness or condition for the payment for hospital, medical or health care services in treatment of such injury, illness or condition to the extent that you receive services from us that are also covered under state or federal worker's compensation, any no-fault insurance, or any liability insurance policy or plan including a self-insured plan.

3. This paragraph applies when another party is, or may be considered liable, for your injury, sickness or other condition (including insurance carriers who are so liable) and Independent Health has provided or paid for benefits.

    a. Independent Health also has the right under 42 CFR 422.108 to collect the reasonable value of the hospital, medical and/or health care benefits paid for or provided to you by Independent Health, other insurers or self-insured plans or from any party liable for your injury, illness or condition or for the payment for hospital, medical, and/or health care services in treatment of such injury, illness or condition. This is known as subrogation. Independent Health may assert this right independently of you.

    b. You are obligated to cooperate with Independent Health and its agents in order to protect Independent Health's subrogation rights. Cooperation means providing Independent Health or its agents with any relevant information requested by them, signing and delivering such documents as Independent Health or its agents reasonably request to secure Independent Health's subrogation claim, and obtaining the express written consent of Independent Health or its agents before releasing any party from liability for payment of Hospital, medical and/or health care expense.

    c. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must provide notice to Independent Health and may not prejudice, in any way, the subrogation rights of Independent Health under this Article.

4. The costs of legal representation of Independent Health in matters related to collection from you or another entity shall be borne solely by Independent Health. The costs of your legal representation shall be borne solely by you.

The rights established under this section are authorized by Federal law and Medicare regulations and cannot be taken away by State law. Independent Health will exercise the same rights to recover from a primary plan, entity or individual that Medicare exercises when Medicare is not the primary payer under the Medicare Secondary Payer regulations.

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

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

Attending Physician – The physician in the Emergency Department who will assess your current condition and care needs. The attending physician will determine whether of not your condition is stable for discharge from the emergency room to your residence or if additional care is medically necessary.

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

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in 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.

Calendar Year – The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require

immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

Emergency Medical Condition – A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

Interqual – A decision support tool used to evaluate the appropriateness of planned health care for a patient. Interqual criteria on current scientific and clinical studies and the opinion of health care experts. Interqual criteria are updated yearly. It improves consistency in health care delivery by providing a standard method for reviewing cases by reducing variations in medical treatment and resource use and by tracking and analyzing patterns of health care.

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

LIBERTY Dental Plan Network Dentist – A dentist who participates in the LIBERTY Dental Plan dental network for Independent Health's Medicare Advantage plans. LIBERTY Dental Plan network dentists provide Independent Health's Medicare Advantage preventive dental and optional comprehensive dental benefits.

Limiting Charge – The highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

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

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

Maximum Charge – Maximum amount that a member can pay out of pocket toward their Medicare plan benefits.

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

Medical Director – The licensed physician designated by Independent Health and the IPA/WNY to exercise general supervision over the provision of medical care rendered by network providers.

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare

prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Independent Health's Encompass 65 (HMO) does not offer Medicare prescription drug coverage.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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

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

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

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

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

Member's Home – For purposes of rental and purchase of DME, a member's home may be a personal dwelling, an apartment, a family member's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for the mentally retarded (ICD/MR)). However, an institution may not be considered a member's home if:

- It meets, at minimum, the basic requirement in the definition of a hospital (i.e., it is primarily engaged in providing, by or under the supervision of physicians, to inpatient,

diagnostic, and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or services for the rehabilitation of injured, disabled, or sick persons.);
- It meets at least the basic requirement in the definition of a skilled nursing facility (i.e. it is primarily engaged in providing skilled nursing care and related services to inpatients who require medical or nursing care, or services for the rehabilitation of injured, disabled, or sick persons.)

Thus, if a member resides in an institution or distinct part of an institution which provides the services described in the bullets above, this would not, for purposes of coverage, be considered the member's home.

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Audiologist – An audiologist is a trained professional who measures hearing loss and can fit hearing aids. You must use an audiologist in the Start Hearing, Inc.network to utilize the hearing aid benefit.

Network Dentist – A dentist who qualifies and agrees to participate in the dental network for Independent Health's Medicare Advantage Program.

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

Opt-Out Practitioner and Physicians – Providers who have filed an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts. Except for emergency or urgently needed services, Independent Health will not cover services provided by opt-out practitioners and physicians through private contracts with a member.

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

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

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

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

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

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Preventive Screening – A service or test considered reasonable and necessary for the prevention or early detection of illness, disease or disability. Independent Health uses CMS guidance and United States Preventive Service Task Force to identify and define preventive screenings. Once a history of illness, disease, or disability has been established, and until there are no longer any signs of illness, disease, or disability, ongoing or future screenings will be considered diagnostic and are subject to member cost sharing as outlined in Chapter 4 of this booklet.

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

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

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

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

Referral – A doctor's recommendation that a patient see a qualified medical professional, often a specialist, to review their health status and determine whether medical treatment is needed or whether a particular course of exercise and/or diet change is safe.

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

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

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Subluxation - a partial abnormal separation of the articular surfaces of a joint. "Subluxation" is used by doctors of chiropractic medicine to depict the altered position of the vertebra and subsequent functional loss, which determines the location for the spinal manipulation.

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.

Urgent Medical Service Facility, In Network – A network provider which is an alternative site of service which is for the purpose of managing acute, non-life-threatening conditions other than in an emergency room of a hospital during non-traditional physician office hours; is not a substitute for routine care provided in the primary care physician's office or as a substitute for care for a medical emergency at the emergency room of a hospital; is equipped to accommodate minor outpatient procedures; provides ancillary services such as laboratory and radiology; directs you to receive any necessary follow-up care from your primary care physician and has entered into an agreement with Independent Health to provide such care to you.

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

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INDEPENDENT HEALTH'S

Medicare Advantage Provider Directories

At Independent Health, we're dedicated to helping you get the right care, at the right time, and in the right setting. That's why we offer a comprehensive network of health care providers, giving you choice and flexibility as to where you receive care.

To help you understand who participates in our network, we've compiled the names of our health care providers and wellness partners into the following directories and listings:

- Independent Health's Medicare Advantage Physician/Provider Directory
- Independent Health's Medicare Advantage Pharmacy Directory
- LIBERTY Dental Plan Dental Directory(for routine/preventive dental providers)
- EyeMed® "Insight Network" Directory (for routine/refractive eye exam providers)
- SilverSneakers® Fitness Program participating facility listing
- Start Hearing participating network provider listing
- Independent Health's Medicare Advantage Part D Formulary (Drug List)

All of this information is available online at **www.independenthealth.com/Medicare.**

If you prefer to receive a copy by mail, please contact Member Services:

PHONE: (716) 250-4401 or 1-800-665-1502; (TTY users call 711)

October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.

April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

EMAIL: medicareservice@servicing.independenthealth.com

For the most up-to-date information on our provider listings, call Member Services or use our "Find a Doctor" tool online at **www.independenthealth.com/findadoc.** This tool gives you the option to search for providers or facilities by name, location or specialty, and print your results.

If you have a question about covered drugs, please call 1-800-665-1502 or visit www.independenthealth.com/MedicareFormularies to access our online formulary. If you would like a formulary mailed to you, you may call the number above, request one at the website link provided above, or email medicareservice@servicing.independenthealth.com.

Notice of Nondiscrimination

Discrimination is Against the Law
Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- 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 Independent Health's Member Services Department. If you believe that Independent Health 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: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 711, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-665-1502. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-665-1502. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-665-1502。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-665-1502。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-665-1502. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-665-1502. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-665-1502 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-665-1502. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-665-1502 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-665-1502. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-665-1502. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-665-1502 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-665-1502. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-665-1502. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-665-1502. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-665-1502. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、
1-800-665-1502 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Independent Health

Independent Health's Encompass 65 (HMO) Member Services

Method	Member Services – Contact Information
CALL	**1-800-665-1502 or 716-250-4401** Calls to this number are free. Hours of operation (Eastern time): October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. After business hours and on Saturdays, Sundays, and holidays please leave a message. Callers should include their name, phone number and the time they called, and a representative will return their call no later than one business day after they leave a message. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** This number is only for people who have difficulties with hearing or speaking. Calls to this number are free. October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.
FAX	**716-631-1039**
WRITE	511 Farber Lakes Drive, Buffalo, NY 14221 medicareservice@servicing.independenthealth.com
WEBSITE	www.independenthealth.com/medicare

Health Insurance Information, Counseling and Assistance Program (HIICAP)

(New York's SHIP) HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	HIICAP Hot Line: 1-800-701-0501
TTY	Call 711
WRITE	Health Insurance Information, Counseling, and Assistance Program New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
WEBSITE	www.aging.ny.gov