January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Independent Health's Medicare Family Choice® (HMO I-SNP)

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1-800-665-1502 or 716-250-4401 for additional information. (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 Medicare Family Choice (HMO I-SNP), 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 Medicare Family Choice (HMO I-SNP).)

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, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or 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 and prescription drug 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_C9264_C H3362_020 Medicare Family Choice HMO I-SNP

OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage

Table of Contents

CHAPTER 1: *Getting started as a member* 5

SECTION 1 Introduction 6

SECTION 2 What makes you eligible to be a plan member? 7

SECTION 3 Important membership materials you will receive 12

SECTION 4 Your monthly costs for Independent Health's Medicare Family Choice (HMO I-SNP) 14

SECTION 5 More information about your monthly premium 17

SECTION 6 Keeping your plan membership record up to date 20

SECTION 7 How other insurance works with our plan 20

CHAPTER 2: *Important phone numbers and resources* 22

SECTION 1 Independent Health's Medicare Family Choice (HMO I-SNP) contacts (how to contact us, including how to reach Member Services) 23

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program) 27

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare) 29

SECTION 4 Quality Improvement Organization 31

SECTION 5 Social Security 32

SECTION 6 Medicaid 33

SECTION 7 Information about programs to help people pay for their prescription drugs 35

SECTION 8 How to contact the Railroad Retirement Board 38

SECTION 9 Do you have group insurance or other health insurance from an employer? 39

CHAPTER 3: *Using the plan for your medical services* 40

SECTION 1 Things to know about getting your medical care as a member of our plan 41

SECTION 2 Use providers in the plan's network to get your medical care 42

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster 48

SECTION 4 What if you are billed directly for the full cost of your services? 51

SECTION 5 How are your medical services covered when you are in a clinical research study? 577
SECTION 6 Rules for getting care in a religious non-medical health care institution....599
SECTION 7 Rules for ownership of durable medical equipment 60

CHAPTER 4: *Medical Benefits Chart (what is covered and what you pay)*.....622

SECTION 1 Understanding your out-of-pocket costs for covered services....633
SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay....655
SECTION 3 What services are not covered by the plan?....1088

CHAPTER 5: *Using the plan's coverage for Part D prescription drugs*.....115

SECTION 1 Introduction....116
SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service 116
SECTION 3 Your drugs need to be on the plan's "Drug List" 120
SECTION 4 There are restrictions on coverage for some drugs 122
SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered? 124
SECTION 6 What if your coverage changes for one of your drugs? 127
SECTION 7 What types of drugs are *not* covered by the plan? 129
SECTION 8 Filling a prescription 130
SECTION 9 Part D drug coverage in special situations....131
SECTION 10 Programs on drug safety and managing medications....132

CHAPTER 6: *What you pay for your Part D prescription drugs*.....135

SECTION 1 Introduction....136
SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug....139
SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in 139
SECTION 4 There is no deductible for Independent Health's Medicare Family Choice (HMO I-SNP)....141
SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share 141

SECTION 6 Costs in the Coverage Gap Stage 146
SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs 146
SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them 147

CHAPTER 7: *Asking us to pay our share of a bill you have received for covered medical services or drugs* 149
SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs 150
SECTION 2 How to ask us to pay you back or to pay a bill you have received 153
SECTION 3 We will consider your request for payment and say yes or no 154

CHAPTER 8: *Your rights and responsibilities* 155
SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan 156
SECTION 2 You have some responsibilities as a member of the plan 174

CHAPTER 9: *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* 176
SECTION 1 Introduction 177
SECTION 2 Where to get more information and personalized assistance 177
SECTION 3 To deal with your problem, which process should you use? 178
COVERAGE DECISIONS AND APPEALS 179
SECTION 4 A guide to the basics of coverage decisions and appeals 179
SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision 182
SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal 189
SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon 199
SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon 206
SECTION 9 Taking your appeal to Level 3 and beyond 212
SECTION 10 How to make a complaint about quality of care, waiting times, Member Services, or other concerns 214

CHAPTER 10: *Ending your membership in the plan*.....220

SECTION 1 Introduction to ending your membership in our plan 221

SECTION 2 When can you end your membership in our plan?.....221

SECTION 3 How do you end your membership in our plan?.....222

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan 224

SECTION 5 Independent Health's Medicare Family Choice (HMO I-SNP) must end your membership in the plan in certain situations.....224

CHAPTER 11: *Legal notices*.....227

SECTION 1 Notice about governing law 228

SECTION 2 Notice about nondiscrimination.....228

SECTION 3 Notice about Medicare Secondary Payer subrogation rights 228

SECTION 4 Miscellaneous Provisions.....229

SECTION 5 Independent Health’s Right to Recover Expenses Paid for by Third Parties and Right of Subrogation.....229

CHAPTER 12: *Definitions of important words*.....2321

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are currently enrolled in Independent Health's Medicare Family Choice (HMO I-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Independent Health's Medicare Family Choice (HMO I-SNP).

Independent Health's Medicare Family Choice (HMO I-SNP) is a specialized Medicare Advantage Plan (a Medicare Advantage Special Needs Plan), which means its benefits are designed for people with special health care needs. Independent Health's Medicare Family Choice (HMO I-SNP) is designed for people who live in an institution (like a nursing home) or who need a level of care that is usually provided in a nursing home.

Our plan includes providers who specialize in treating patients who need this level of care. As a member of the plan, you get specially tailored benefits and have all your care coordinated through our plan.

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

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

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

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of Independent Health's Medicare Family Choice (HMO I-SNP).

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

If you are confused, concerned, or just have a question, please contact 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 Medicare Family Choice (HMO I-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Independent Health's Medicare Family Choice (HMO I-SNP) between January 1, 2024 and December 31, 2024.

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 Medicare Family Choice (HMO I-SNP) after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic 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
- -- *and* -- you meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home.

To be eligible for our plan, you must meet one of the two requirements listed below.

- You live in a nursing home available through our plan. Here is a list of our contracted nursing homes:

Independent Health Medicare Family Choice (HMO-SNP) **Participating Skilled Nursing Facilities:** (As of July 2023)			
Facility Name	**Location**	**Address**	**Zip**
Absolut Facilities			
Absolut Care of Aurora Park	East Aurora	292 Main Street	14052
Absolut Care of Gasport	Gasport	4540 Lincoln Drive	14067
Avante Facilities			
Fiddler's Green Manor Rehabilitation and Nursing	Springville	168 W. Main St.	14141
Humboldt House Rehabilitation and Nursing Center	Buffalo	64 Hager St.	14208
Niagara Rehabilitation and Nursing	Niagara Falls	822 Cedar Ave	14301
Catholic Health System			
Father Baker Manor	Orchard Park	6400 Powers Road	14127
McAuley Residence	Kenmore	1503 Military Road	14217
Mercy Nursing Facility at OLV	Lackawanna	55 Melroy Ave.	14218
St Catherine Laboure Health Care Center	Buffalo	2157 Main Street	14214
Comprehensive Facilities			
Comprehensive at Williamsville, LLC	Williamsville	147 Reist Street	14221
Elderwood Nursing Facilities			
Elderwood at Amherst	Amherst	4459 Bailey Avenue	14226
Elderwood at Cheektowaga	Cheektowaga	225 Bennett Road	14227
Elderwood at Grand Island	Grand Island	2850 Grand Island Blvd.	14072
Elderwood at Hamburg	Hamburg	5775 Maelou Drive	14075

Independent Health Medicare Family Choice (HMO-SNP) Participating Skilled Nursing Facilities: (As of July 2023)			
Elderwood at Lancaster	Lancaster	1818 Como Park Blvd	14086
Elderwood at Lockport	Lockport	104 Old Niagara Road	14094
Elderwood at Wheatfield	Niagara Falls	2600 Niagara Falls Blvd	14304
Elderwood at Williamsville	Williamsville	200 Bassett Road	14221
Erie County Medical Center			
Terrace View Long Term Care Facility	Buffalo	462 Grider Street	14215
Kaleida Corporation			
Kaleida DeGraff Skilled Nursing Facility	North Tonawanda	445 Tremont Street	14120
Kaleida HighPointe on Michigan	Buffalo	1031 Michigan Avenue	14203
The McGuire Group Corporation			
Autumn View Health Care Facility	Hamburg	4650 Southwestern Blvd	14075
Garden Gate Health Care Facility	Cheektowaga	2365 Union Road	14227
Harris Hill Nursing Facility	Williamsville	2699 Wehrle Drive	14221
Northgate Health Care Facility	North Tonawanda	7264 Nash Road	14120
Seneca Health Care Facility	West Seneca	2987 Seneca Street	14224
Sapphire Care Group			
Williamsville Suburban	Williamsville	193 South Union Rd.	14221
Independent Facilities			
Beechwood Nursing Home	Getzville	2235 Millersport Hwy	14068

Independent Health Medicare Family Choice (HMO-SNP) **Participating Skilled Nursing Facilities:** (As of July 2023)			
Brothers of Mercy Nursing Facility	Clarence	10570 Bergtold Road	14031
Buffalo Center for Rehabilitation and Nursing	Buffalo	1014 Delaware Avenue	14209
Greenfield Health and Rehabilitation Center	Lancaster	5949 Broadway	14086
Lockport Rehab and Health Care Center	Lockport	909 Lincoln Avenue	14094
Newfane Rehabilitation and Health Care Center	Newfane	2709 Transit Road	14108
Our Lady of Peace Nursing Care Residence	Lewiston	5285 Lewiston Road	14092
Schoellkopf Rehabilitation Facility	Niagara Falls	621 Tenth Street	14301
Schofield Residence	Kenmore	3333 Elmwood Avenue	14217
Weinberg Campus - Rosa Coplon	Getzville	2700 North Forest Road	14068

- -or – you live at home and our plan has obtained certification that you need the type of care that is usually provided in a nursing home.

Independent Health Medicare Family Choice (HMO-SNP) Participating Assisted Living Program Facilities; (As of July 2023)			
Absolut Care of Orchard Brooke	Orchard Park	6050 Armor Duells Rd.	14127
Sacred Heart Home	Clarence	4520 Ransom Road	14031
Tennyson Court	Williamsville	49 Tennyson Terrace	14221
Wheatfield Commons	North Tonawanda	3920 Forest Parkway	14120

- Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 30 days, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 Here is the plan service area for Independent Health's Medicare Family Choice (HMO I-SNP)

Independent Health's Medicare Family Choice (HMO I-SNP) 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.

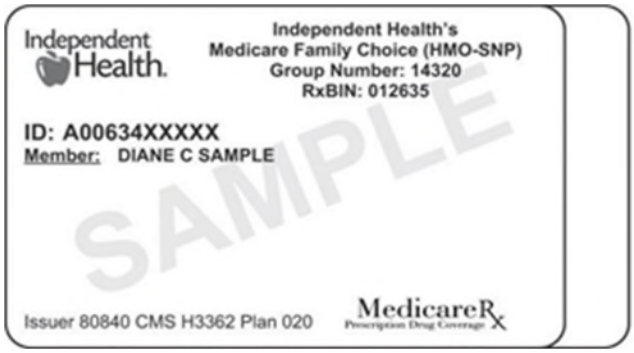
Section 2.3 U.S. Citizen or Lawful Presence

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 Medicare Family Choice (HMO I-SNP) if you are not eligible to remain a member on this basis. Independent Health's Medicare Family Choice (HMO I-SNP) 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 and for prescription drugs you get at network pharmacies. 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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP) 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 *provider directories*:

- *Physician/Provider Directory (and medical dental and vision providers)*
- *Pharmacy Directory*
- *EyeMed "Insight Network" Directory (link to on-line searchable directory for routine/refractive eye exam providers)*
- *SilverSneakers® Fitness Program participating facility listing*
- *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 3.3 Pharmacy Directory

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services. You can also find this information on our website at www.independenthealth.com/Medicare.

Section 3.4 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Independent Health's Medicare Family Choice (HMO I-SNP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Independent Health's Medicare Family Choice (HMO I-SNP) "Drug List."

The “Drug List” also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the “Drug List.” To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.independenthealth.com/MedicareFormularies) or call Member Services. You can also e-mail a request for a Drug List to medicareservice@servicing.independenthealth.com.

SECTION 4 Your monthly costs for Independent Health's Medicare Family Choice (HMO I-SNP)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Member Services, and ask for the LIS Rider.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2024, the monthly premium for Independent Health's Medicare Family Choice (HMO I-SNP) is $48.70.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **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.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in Independent Health's Medicare Family Choice (HMO I-SNP), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
    - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.70, which equals $4.86. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional

IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.

Option 1: Paying by check

You may decide to pay your monthly plan premium directly to our Plan with a check.

Premium payments are due by the first of the month. Checks should be made payable to Independent Health and not CMS nor HHS. To pay by check, members may:

- **Pay in Person to:**
  Independent Health
  250 Essjay
  Buffalo, NY 14221

- **Mail to:**
  Independent Health
  Dept. 858, PO Box 8000
  Buffalo, NY 14267-0002

Option 2: You can pay by automatic withdrawals from your bank account, or credit card

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank. Automatic deductions can occur monthly and is recommended that they are set

up to pull between the 1st and the 7th day of the month, to avoid receiving a delinquent letter. Automatic deductions can occur monthly. Please call Member Services (the phone number is on the back cover of this booklet) to set up this optional method of payment and to update any changes to your account once enrolled or you can check the “direct debit” box on your Invoice, sign and attach your account information and return the form to us.

Option 3: Having your plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 4: You can pay your premium online

Online bill pay provides an easy and hassle-free way for you to pay your Independent Health premium each month. With your invoice in hand, you can quickly and securely pay your bill using any major credit or debit card, or your checking account.

- **Pay online at:**
  www.independenthealth.com/MedicarePay

Members who receive “extra help” from EPIC:

Why do I have to pay my invoice in full if I am expecting premium assistance from Epic?

- It could take several months before the New York State Department of Health provides us with confirmation about your EPIC eligibility for 2024. Upon confirmation, the DOH will send Independent Health the first EPIC payment for 2024. However, until we start receiving your EPIC payments for 2024, you’ll be responsible for the total cost of your monthly premium.

With regards to refunds:

When will I get refunded if I’m paying for Epic in advance?

EPIC sends us one payment per month to cover your subsidy. Since it could take several months before we receive your initial EPIC subsidy payment, we would not receive the final payments for 2023 until early 2024. If you remain with Independent Health next year, those payments would be applied to your monthly plan premium for the first few months of 2024. As a result,

there will be no gap in us receiving payments from EPIC in 2024. If you choose not to stay with Independent Health, we would refund those subsidy payments when we receive them in 2024.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the first day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 90 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at (716)250-4401 or 1-800-665-1502 between October 1 – March 31: Monday-Sunday, 8 a.m. to 8 p.m. April 1 – September 30: Monday-Friday 8 a.m. to 8 p.m. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 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.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility

for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay part of the member’s monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

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, pharmacists, 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 and drugs 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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP) 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 and/or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. 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 or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – 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** Pharmacy Coverage Determinations Fax: 716-631-9636
WRITE	Part D Coverage Determination: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221 Medical Coverage Determinations: Independent Health Appeals and Complaints, PO 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 and/or Part D prescription drugs

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

Method	Complaints About Medical Care – Contact Information
CALL	**1-800-665-1502 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, PO Box 2090, Buffalo NY 14231 email: Appeals@independenthealth.com
MEDICARE WEBSITE	You can submit a complaint about Independent Health's Medicare Family Choice (HMO I-SNP) 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 or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

Method	Payment Requests – 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 Part D drugs:** Independent Health PO Box 9066 Buffalo, NY 14231-9066 Attn: Pharmacy Department **For Vision Claims:** EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
WEBSITE	www.independenthealth.com

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

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

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

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

Method	Medicare – Contact Information
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes 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 Medicare Family Choice (HMO I-SNP) • **Tell Medicare about your complaint:** You can submit a complaint about Independent Health's Medicare Family Choice (HMO I-SNP) 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	711 This number is only for people who have difficulties with hearing or speaking.
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
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 DeCarlo, 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**
CALL	1-866-815-5440
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.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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 the 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 Plaza, Albany, NY 12237
E-MAIL	Email: 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 Batavia, New York 14020 (585) 344-2580
Cattaraugus County (Main Office) Cattaraugus County DSS Cattaraugus County Building 1 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)753-4000	**Orleans County** Orleans County DSS 14016 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 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

Our Plan's process for providing best available evidence, including the time limitation for receiving supporting documentation
Member/Member's Representative contacts Independent Health Medicare Servicing, 1-800-665-1502, and informs that, based on extra help or Low Income Subsidy (LIS), they should have a more favorable level/cost share for prescriptions compared to what is currently on the health plan/pharmacy systems. Member/Member's Representative is instructed to send documentation that supports a more favorable level of extra help, also known as Best Available Evidence (BAE), to Independent Health 's Medicare Servicing. The address is on the back cover of this book. Member/Member's Representative **has BAE**: once acceptable BAE is presented, Independent Health will immediately provide access to prescriptions at a more favorable level/cost share as indicated by the BAE and fully update its systems within 48 to 72 hours. Independent Health will submit BAE to the Centers for Medicare & Medicaid Services (CMS) if CMS systems are not updated timely to show the more favorable level/cost share. Member/Member's Representative **does not have BAE**: Independent Health Medicare Servicing will determine how much medication the member has remaining and escalate the case for research and inquiry with CMS. Once a response is received from CMS regarding extra help/LIS eligibility, any appropriate systems updates will take place and Independent Health Medicare Servicing will notify the member/member representative of the result of this inquiry.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Member Services if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the In New York State contact the New York State Department of Health/ADAP (www.health.ny.gov/diseases/aids/general/resources/adap/eligiblity.html).

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call.

#Method	ADAP New York State Department of Health – Contact Information
CALL	1-800-542-2437 TTY: 711
WRITE	New York State Department of Health (NYDOH) Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220-0052 adap@health.state.ny.us
WEBSITE	www.health.ny.gov (www.health.ny.gov/diseases/aids)

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In New York, the State Pharmaceutical Assistance Program is **New York State Elderly Pharmaceutical Insurance Coverage Program (EPIC).**

Method	New York State Elderly Pharmaceutical Insurance Coverage Program (EPIC) (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	**1-800-332-3742** 8:30 a.m. to 5:00 p.m., Monday through Friday
TTY	**1-800-290-9138** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**EPIC** P.O. Box 15018 Albany, NY 12212-5018
WEBSITE	www.health.ny.gov/health_care/epic

SECTION 8 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 Help Line 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 9 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.

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

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, Independent Health's Medicare Family Choice (HMO I-SNP) must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Independent Health's Medicare Family Choice (HMO I-SNP) 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 care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 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?

What is a PCP?

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. 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. Please refer to your Physician/Provider Directory for a listing of physicians designated as Family Choice PCPs. A PCP may also coordinate the rest of the covered services you get as a plan member.

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 preauthorization (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 get care from a Family Choice Nurse Practitioner (NP) or Physician Assistant (PA)?

- A nurse practitioner is a registered nurse who has a Master’s Degree in Nursing, undergone extensive classroom and clinical training and is licensed by the State of New York to write prescriptions and order treatments and other services just as physicians do.
- A physician assistant has graduated from an accredited physical assistant program, undergone extensive classroom and clinical training and is licensed by the State of New York to write prescriptions and order treatment under the supervision of a physician.
- As soon as you join Independent Health's Medicare Family Choice (HMO I-SNP), you will be assigned to an Interdisciplinary Care Team which includes a Nurse Practitioner or Physician Assistant, your PCP, a social worker, you, your family or responsible party and your caregivers in the facility.

- A member of the Interdisciplinary Care Team will conduct an initial health risk assessment. We will notify your PCP that you have selected Independent Health's Medicare Family Choice (HMO I-SNP) and your care team will work collaboratively with your caregivers, your physician and your loved ones to provide and coordinate all the Medicare services you receive.
- The focus of your care will be frequent monitoring, early intervention when problems are identified and providing as many services as possible in your place of residence, so you don't have to make unnecessary trips to the emergency room or hospital.
- Your Nurse Practitioner or Physician Assistant will visit you at least once per month and more frequently if your condition requires closer monitoring or you experience an illness. In addition, she/he will help keep your family and/or loved ones aware of the care you are receiving. Your PCP will continue to see you just as he/she has in the past. Besides providing some of your care, your Nurse Practitioner or Physician Assistant will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other network providers about your care. In some cases, your Nurse Practitioner or Physician Assistant may also need to get preauthorization for certain types of covered services or supplies (prior approval from Independent Health).

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 a participating "Network Provider with Medicare Family Choice Plan" as indicated in 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 should have all of your past medical records sent to your new Primary Care Physician's office.

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, 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 services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- 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. When you use services from a non-network provider, it is recommended, but not required, that you get provider preauthorization. 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 9, Section 4, about coverage decisions.

What is the role (if any) of the PCP or Family Choice NP or PA in referring members to specialists and other providers?

- When your PCP, NP or PA 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, NP or PA 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 preauthorization.

- If there are specific specialists you want to use, find out whether your PCP, NP or PA sends patients to these specialists. Each Plan PCP, NP or PA has certain network specialists they use to coordinate care. This means that the PCP, NP or PA may determine the specialists you may see. You may generally change your PCP at any time if you want to see a network specialist that your current PCP can't refer you to. Earlier in this section (Section 2.1), under "How can you switch to another PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether the doctors you will be seeing use these hospitals. 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?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.

  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure that the medically necessary treatment or therapies you are receiving continues.
- 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 9.

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 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 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 preauthorization 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 covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

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

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent 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 United States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written detailed bill or an 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, 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.

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 United States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records. See Chapter 4 for limitations. If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable, and the medical emergency is over. Post stabilization care is not covered outside of the country.

Your PCP, NP or PA 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?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

Your primary care physician can also provide or arrange for all non-emergency and urgently needed care. Your Family Choice Nurse Practitioner or Physician Assistant will work in collaboration with your PCP to provide urgently needed care 24 hours a day, 7 days a week. If you need to get in touch with the Family Choice NP/PA, please call the Family Choice office between 8:30-5:00 M-F at 716-688-7051 or 1-800-506-7051. (TTY users 711). For after hours and weekends, your facility staff can assist you in contacting your Family Choice NP/PA.

- You can receive urgent care from an urgent care center or walk-in clinic.
- Use our web tool to locate an urgent care center 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

As a supplemental benefit, our plan covers emergency/urgent services world-wide but does not cover routine care outside of the United States.

- **If you can't reach your Primary Care Physician, you can 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.

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 emergency, urgent care, and ambulance services are subject to a maximum plan benefit limit of $10,000 per year for coverage outside of the USA. Coverage ends when the $10,000 limit is reached or when the member becomes stable, whichever happens first. We will work with the attending physician to determine when you are stable.

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. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) 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 Medicare Family Choice (HMO I-SNP) 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 4.3 Hospital care, skilled nursing facility care, and other services

How do you get hospital care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in Chapter 4 under the heading “Inpatient Hospital Care”

What is a “benefit period” for hospital care?

Our Plan uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are admitted to the hospital and are receiving inpatient services in the hospital). A “benefit period” begins on the first day you are admitted as an inpatient at a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, then a new benefit period begins. There is no limit to the number of benefit periods you may have. See Chapter 4 for your cost sharing information and any applicable day limits. As shown in the Benefits Chart in Chapter 4, you must pay the inpatient hospital copayment once per benefit period. There is an annual out-of-pocket maximum of $600 for inpatient hospitalization.

What happens if you join or leave our Plan during a hospital stay?

If you either join or leave Our Plan during an inpatient hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Family Choice of New York. Family Choice of New York can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a Plan member.

What is a “hospitalist”?

In most cases, you will be admitted to the hospital where your network primary care physician or network admitting specialist has privileges. However, some doctors have chosen to use the services of a hospitalist to provide care to their patients when they are in the hospital. Some physicians use hospitalists because they do not have admitting privileges at a network hospital. A hospitalist is a primary care physician who is employed by, or under contract with, a network hospital or network physician to provide primary care services to you while you are in the hospital. If you want to know whether your network provider uses a hospitalist you can contact Independent Health’s Member Services.

What is skilled nursing facility care?

“Skilled nursing facility care” means a level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve

the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

How do you get skilled nursing facility care (SNF care)?

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in Chapter 4 under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell you more about some rules that apply to your covered services.

As a member of our Plan, you must receive skilled care in a facility that participates in the Family Choice Plan network. If you are a permanent resident of a facility, you will receive care in your own facility. If you live in the community you will receive care in one of our network facilities. For a full listing of all Independent Health’s Medicare Family Choice network skilled facilities located in Western New York, please refer to the Physician/Provider Directory.

Are Nursing Home stays that provide custodial care covered?

“Custodial care” is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don’t have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. We don’t cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

What are the benefit period limitations on coverage of skilled nursing facility care?

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A **“benefit period”** begins on the first day you are admitted as an inpatient at a Medicare-covered hospital or SNF. The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Chapter 4 under the heading, “Inpatient services covered during a non-covered inpatient stay.”

What are the situations when you may be able to get care in a skilled nursing facility (SNF) that isn't a network provider?

Generally, you will get your skilled nursing facility care from network SNFs. However, under certain conditions shown below, you may be able to pay the plan cost sharing (See Chapter 4) for skilled nursing facility care from a SNF that isn't a network provider if the SNF 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 the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

What happens if our Plan doesn't authorize your care?

- Except in cases of medical emergencies your provider must obtain prior authorization for your SNF stay. You and the facility providing care will receive written and verbal notification from Independent Health to let you know if prior authorization has been granted.

What happens if you join or leave Independent Health's Medicare Family Choice during a skilled nursing facility (SNF) stay?

If you either join or leave our Plan during a SNF stay, please call Family Choice of New York. Family Choice of New York can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and weren't a Plan member.

How do you get home health care?

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4 under the heading "Home health care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements listed below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

- You must be homebound. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.
- You may still be considered homebound even if you have occasional absences from the home for non-medical purposes, such as an occasional trip to the barber/hairdresser or a walk around the block or a drive if the absences are infrequent or are of relatively short

duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

- Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. “Supportive devices” include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.
- Your doctor and Nurse Practitioner or Physician Assistant must decide that you need medical care in your home, and must make a Plan for your care at home. Your Plan of care describes the services you need, how often you need them, and what type of health care worker should give you these services.
- The home health agency caring for you must be approved by the Medicare Program.
- You must need at least one of the following types of skilled care:
    - Skilled nursing care on an “intermittent” (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
    - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
    - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
    - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

When can home health care include services from a home health aide?

As long as some qualifying skilled-nursing services are also included, the home health care you get can include services from a home health aide. A home health aide doesn’t have a nursing license or provide therapy. The home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). The services from a home health aide must be part of the home “Care Plan” for your illness or injury, and they aren’t covered unless you are also getting a covered skilled nursing service. “Home health services” don’t include the services of housekeepers, food service arrangements, or full time nursing care at home.

What are “part-time” and “intermittent” home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for “part-time” or “intermittent” skilled nursing services and home health aide services:

- "Part-time" or "intermittent" means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is hospice care?

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

How do you get hospice care if you are terminally ill?

As a member of our Plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Independent Health's member services department to get a list of the Medicare-certified hospice providers in your area (phone numbers are located on the back of this booklet). You may also call the Regional Home Health Intermediary at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

How is your hospice care paid for?

If you enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or a non-network provider. Even if you choose to enroll in a Medicare-certified hospice, you will still be a Plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. If you use non-network providers for your routine care, Original Medicare (rather than our Plan) will cover your care and you will have to pay Original Medicare out-of-pocket amounts. Note: if you are enrolled in Part B only and not entitled to Part A, you should call us to get information on our Hospice coverage.

How to get more information on hospice care

Visit www.medicare.gov on the Web. Under "Search Tools," "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to get an organ transplant if you need it

If you need an organ transplant, we will work with your physician to arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center:

heart, liver, lung, heart-lung, and intestinal/multivisceral transplants. See Chapter 4 for any cost sharing information.

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 (NCDs) and investigational device trials (IDE) 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.

- We can let you know whether the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

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 7 for more information for submitting requests for payments.

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

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

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

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 Medicare Family Choice (HMO I-SNP), 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 switch to Original Medicare after being a member of our plan: 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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP). 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 the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $3,000.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.) If you reach the maximum out-of-pocket amount of $3,000, 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 your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan 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 1.4 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 $600 for covered Inpatient Hospital care. Once you have paid $600 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 $3,000 for Part A and Part B medical services or $600 for your Inpatient Hospital care, the plan will cover your Inpatient Hospital care at no cost to you for the rest of the year. The benefits chart in Section 2 shows the service category out-of-pocket maximums.

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

As a member of Independent Health's Medicare Family Choice (HMO I-SNP), 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 Medicare Family Choice (HMO I-SNP) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. 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.
- 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. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- 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)**.

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 2024* 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 2024, either Medicare or our plan will cover those services.
- If you are within our plan's 30 day period of deemed continued eligibility, we will continue to provide all plan-covered benefits, and your cost sharing amounts do not change during this period.

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 $3,000 out-of-pocket maximum in-network. Premiums, optical dispensing, routine eyewear cost in excess of annual limit, Medicare Part D prescription drugs, preventive/routine dental, hearing aid evaluation exam, and hearing aids do NOT count towards the out-of-pocket maximum. Costs incurred for services outside of the United States are not included in the annual Out-of-Pocket Maximum.

Services that are covered for you	**What you must pay** when you get these services
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 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	$0 copayment per visit

Services that are covered for you	**What you must pay** when you get these services
accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Worldwide Ambulance Coverage • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. **Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.** • See "Transportation for non-emergency transportation."	**(Provider preauthorization is required for planned transportation only)** $80 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. **Outside United States and its territories:** Emergency: $100 copayment Urgent care: $0 copayment Ground Ambulance: $80 copayment Air Ambulance: 20% coinsurance

Services that are covered for you	**What you must pay** when you get these services
	Worldwide coverage: Maximum plan benefit limit of $10,000 per occurrence for unforeseen care outside of the United States and its territories. Coverage ends when $10,000 limit is reached.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
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.
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 Medicare-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. Cardiac Rehabilitation is a program consisting of 36 visits. There must be a written order from the provider for this service to be covered. After the member completes the program, if the provider believes that it is medically necessary and that the member would benefit from completing the program a second time, the provider will be required to produce another written order for the service to be covered.	$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.
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 • 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	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.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	$0 copayment per visit for Medicare-covered services.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA Based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
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.	See Physician Services – Non-Routine Dental for Medicare-covered dental coverage.

Services that are covered for you	**What you must pay** when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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**	**(Certain items may require provider preauthorization)** Supplies used with the administration of insulin are covered under Part D (i.e., syringes) For Omni-pod coverage reference your formulary by visiting www.independenthealth.com/medicare. $0 copayment for blood glucose monitor. Limited to preferred products such as OneTouch® manufactured by Lifescan: • OneTouch® Verio Flex™ • OneTouch® Verio® • OneTouch® Verio® IQ • OneTouch® UltraMini™ • OneTouch® Ultra®

Services that are covered for you	**What you must pay** when you get these services
• **Lancets**	$0 copayment 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 copayment 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 monitors and supplies 10% coinsurance for non-therapeutic continuous glucose monitors and supplies Limited to preferred continuous glucose monitors and supplies. These are no longer covered through medical supply or durable medical equipment providers and only covered through network pharmacies.

Services that are covered for you	**What you must pay** when you get these services
• **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-in-lay 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.** • Office visit with and Endocrinologist	**Diabetic self-management training:** Covered in full With a diagnosis of diabetes, members can see an In Network Endocrinologist at $0 copayment. **If you have been diagnosed with diabetes:** $0 copayment for Endocrinologist with diagnosis of Diabetes.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular covered 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. 10% coinsurance for all other covered DME items. For a list of covered items, see the chart at the end of this table. 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

Services that are covered for you	**What you must pay** when you get these services
	Email: Contact@peoplefirstmobility.net Website: www.peoplefirstmobility.net Please see Section 3.1 of this chapter for additional information on DME coverage. Your cost sharing for Medicare oxygen equipment coverage is 10% 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 Medicare Family Choice you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Independent Health's Medicare Family Choice is 10% coinsurance.
Emergency care ***Worldwide Emergency/Urgent Coverage*** 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	$100 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

Services that are covered for you	**What you must pay** when you get these services
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.	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 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:** Emergency: $100 copayment Urgent care: $0 copayment Ground Ambulance: $80 copayment Air Ambulance: 20% coinsurance Worldwide coverage: Maximum plan benefit limit of $10,000 per occurrence for unforeseen care outside of the USA and its territories. Subject to a combined annual plan limit of $10,000.

Services that are covered for you	**What you must pay** when you get these services
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** Two times 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. • **Health and Wellness Classes** Educational seminars and classes offered by community providers which address a variety of health-related topics. There are fitness 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	$20 copayment for certain community fitness 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
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, 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 Programs, 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.	

Services that are covered for you	**What you must pay** when you get these services
• **Fitness Benefits:** Fitness membership	$0 copayment for Fitness Program gym membership. SilverSneakers gives you FREE access • 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 • SilverSneakers FLEX®, giving you options to get active outside of traditional gyms (like recreation centers, malls and parks) • Online fitness and nutrition tips 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 plan year to plan year.

Services that are covered for you	**What you must pay** when you get these services
	Memberships will restart on January 1st of each year. Benefit may change on January 1st of each year. Member cannot combine any promotional offers with our SilverSneakers Fitness Program.
Help with Certain Chronic Conditions If the member has been diagnosed by a plan provider with certain chronic conditions and meets certain criteria, they may be eligible for reduced cost sharing, as described below. The chronic conditions and cost sharing reductions must be listed here. If a member is diagnosed with diabetes, they may have reduced cost sharing for the following services: • Office visits with an endocrinologist If a member has been diagnosed with lower back pain, they will have reduced cost sharing for the initial evaluation with a physical therapist and the first physical therapy session. After that, the copayment for outpatient rehabilitation services (described in Chapter 4, Section 2) will apply. If a member has been diagnosed with depression, the first visit with a mental health provider will have reduced cost sharing. After that, the outpatient mental health copayment (described in Chapter 4, Section 2) will apply.	If a member has been diagnosed with diabetes: $0 copayment for an office visit with an endocrinologist. If you have been diagnosed with lower back pain: $0 copayment for initial evaluation with a physical therapist $0 copayment for first physical therapy session If you have been diagnosed with depression: $0 copayment for first visit with a participating mental health provider.
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.

Services that are covered for you	**What you must pay** when you get these services
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 Home infusion drugs in the home (requires Part B or Part D coinsurance)	**(Requires Provider preauthorization.)** 10% coinsurance for Medicare-covered durable medical equipment and supplies. See Durable Medical Equipment in this chart for benefit details. $0 copayment for Home Health agency care. Supplies are covered in full when medically necessary.
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 • 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	$0 copayment See Medicare Part B Drugs for Home Infusion Drug cost sharing.

Services that are covered for you	**What you must pay** when you get these services
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 For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal diagnosis: 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 diagnosis. 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. For services that are covered by Medicare Part A or B and are not related to your terminal diagnosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal diagnosis, 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	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 Medicare Family Choice (HMO I-SNP). Must be a Medicare-certified Hospice.

Services that are covered for you	**What you must pay** when you get these 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) For services that are covered by Independent Health's Medicare Family Choice (HMO I-SNP) but are not covered by Medicare Part A or B: Independent Health's Medicare Family Choice (HMO I-SNP) 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 diagnosis. You pay your plan cost sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (*What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal diagnosis), 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
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
• Other vaccines if you are at risk and they meet Medicare Part B coverage rules	$0 copayment for other Part B vaccines

Services that are covered for you	**What you must pay** when you get these services
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 abuse services • Detoxification • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/ lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. 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 Medicare Family Choice (HMO I-SNP) provides transplant services at a location outside	(**Requires provider preauthorization except for emergency admissions)** $250 copayment per stay Cost sharing is charged for each inpatient stay. Subject to $600 annual copayment maximum. 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. 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.

Services that are covered for you	**What you must pay** when you get these services
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.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**(Requires provider preauthorization except for emergency admissions)** $250 copayment per day for days 1 through 5 per benefit period. $0 copayment per day, days 6 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

Services that are covered for you	**What you must pay** when you get these services
	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. You are responsible for the maximum number of per day cost shares for each benefit period. If you are discharged from the hospital less than prior to using the maximum number of per day cost shares, and you are if 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. 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.
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.	

Services that are covered for you	**What you must pay** when you get these services
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 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 3.1. 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-	

Services that are covered for you	**What you must pay** when you get these services
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 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 an organizational determination from Independent Health. The hospital may request this on your behalf. If Independent Health renders an adverse determination (denial for admission), 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 As described above, the plan covers unlimited days per benefit period for Medicare-covered inpatient hospital care. 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:	**(Certain services may require 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
• Lab test (inpatient)	$0 copayment for each Medicare-covered lab test. 20% coinsurance for molecular or predisposition genetic testing.

Services that are covered for you	**What you must pay** when you get these services
• Diagnostic tests, such as: o Electromyelogram (EMG) o Stress Tests (See Advanced Radiology for Nuclear Stress Tests) o Echocardiograms o EKG	$0 copayment for each diagnostic test
• X-rays	10% coinsurance for the x-ray or advanced radiology service**
• Advanced Radiology Diagnostic Services (Like CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imagine and PET scans)	10% coinsurance for the radiologist**
• Radiation Therapy: radium, and isotope therapy including technician materials and services	10% coinsurance for Medicare-covered Radiation Therapy** **Coinsurance will apply for a diagnostic x-ray and an advanced radiology service if both are billed on the same day by the same provider.
• 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 10% coinsurance for each external prosthetic or orthotic.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition	10% coinsurance for each Medicare-covered brace; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of

Services that are covered for you	**What you must pay** when you get these services
	breakage, wear, loss, or a change in the patient's physical condition. 10% coinsurance for each Medicare-covered ostomy supply.
• Physical therapy, speech therapy, and occupational therapy	$0 copayment for each Medicare-covered physical therapy, speech therapy, and occupational therapy treatment or evaluation.
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.
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.	This is a 2-year program and has a once per lifetime limit. There is no coinsurance, copayment, or deductible for the MDPP benefit.

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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of part B Drug 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 and Part D prescription drug benefit Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	(**Certain services may require provider preauthorization)** $0 copayment for each Medicare-covered Part B drug. If a Part B drug is administered in the office, outpatient hospital setting or home, subject to $0 copayment in addition to the office/outpatient/home health agency member liability. Insulin is subject to a cost share cap of $0 for one-month's supply of insulin.

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 counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$0 copayment per visit for Medicare-covered Opioid Treatment Program services. If a drug is administered in the office: $0 copayment in addition to the office copay. If a drug is obtained in a pharmacy: see your drug list for appropriate tier and pricing.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays	**(Certain services may require provider preauthorization)** 10% coinsurance for each Medicare-covered x-ray** 10% coinsurance for the radiologist**

Services that are covered for you	**What you must pay** when you get these services
• Advanced Radiology Services (Like CT Scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET Scans.)	10% coinsurance for the advanced radiology service** 10% coinsurance for the radiologist**
• Radiation (radium and isotope) therapy including technician materials and supplies	10% coinsurance for each Medicare-covered radiation therapy
• 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 each Medicare-covered item used to treat fractures and dislocations
• Laboratory tests (outpatient)	**(Certain services may require provider preauthorization)** $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 or office visit copayment

• Other outpatient diagnostic tests such as:
  • Electromyelogram (EMG)
  • Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests)
  • Echocardiograms
  • EKG
	$0 copayment for each Medicare-covered diagnostic test**

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.	$250 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. Services in an emergency department such as: • Observation Bed services	**(Provider preauthorization may apply for some services except for services in an emergency department)** $250 copayment If Emergency Room and Observation Facility are billed on

Services that are covered for you	**What you must pay** when you get these services
	same day the Observation copay will be taken.
• Services in an outpatient clinic	$0 copayment in an outpatient clinic
• Same day outpatient surgery (Includes diagnostic "scopes" such as an endoscopy)	10% coinsurance for each Medicare-covered surgery in an Ambulatory Surgical Center. 10% coinsurance for each Medicare-covered procedure in an outpatient hospital.
• Laboratory tests (outpatient)	$0 copayment for each Medicare-covered lab test. 20% coinsurance for molecular and predisposed genetic testing.
• Diagnostic tests billed by the hospital, such as: • Electromyelogram (EMG) • Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests) • Echocardiograms • EKG	$0 copayment for diagnostic tests from a Primary Care Physician $0 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	**(Certain services may require provider preauthorization)** $0 copayment per outpatient mental health visit $0 copayment for each partial hospitalization visit
• X-rays	10% coinsurance for the x-ray**
• Advanced Radiology Services (Like CT Scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET Scans.)	10% coinsurance for the radiologist**

Services that are covered for you	**What you must pay** when you get these services
• Radiation (radium and isotope) therapy including technician materials and supplies	10% coinsurance for the advanced radiology service** 10% coinsurance for the radiologist** 10% coinsurance for Medicare-covered radiation therapy 10% coinsurance for the radiologist**
• 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 **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.	$0 copayment (May require provider preauthorization. See Medicare Part B drugs) $0 copayment for certain biologicals you can't give yourself. If a Part B drug is administered in the office, home, or outpatient hospital setting, subject to the office/outpatient member liability

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$0 copayment for Medicare-covered services listed in column to the left.
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).	$0 copayment for each Medicare-covered outpatient rehabilitation service, treatment, or evaluation.
Outpatient substance abuse services Outpatient medical treatment for alcohol abuse, chemical abuse and chemical dependency.	$0 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)** 10% coinsurance for freestanding Ambulatory Surgical Center 10% coinsurance for 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 2024 Physician/Provider Directory.
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	$100 allowance every three months. Allowance is made available by quarter (January 1st, April 1st, July 1st, October 1st). Allowance carries

Services that are covered for you	**What you must pay** when you get these services
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.	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 or therapist'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 or therapist'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.	**(Requires provider preauthorization)** $0 copayment per visit for Medicare-covered services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office • Medically-necessary medical care or surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist	$0 copayment if emergent care provided in a Primary Care Physician's office $0 copayment for consultation by a Specialty Physician Freestanding Ambulatory Surgical Center or Outpatient Hospital Facility: 10% coinsurance $0 copayment for a second opinion by a Specialist

Services that are covered for you	**What you must pay** when you get these services
• 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 a basic hearing exam by a Primary Care Physician $0 copayment for a basic hearing exam by a Specialty Physician
• **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 receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth. Contact your Provider(s) to see if they participate in telehealth services. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • 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	$0 copayment for certain telehealth services with a Primary or Specialty Physician $0 copayment for Specialty Physician telehealth services in a rural location. $0 copayment for a telehealth visit for Physical Therapy, Speech Therapy, or Occupational Therapy. $0 copayment for a telehealth visit with a mental health professional. $0 copayment for a telehealth visit for urgent care.

Services that are covered for you	**What you must pay** when you get these services
○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send; to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient	
• Second opinion by another network provider prior to surgery	$0 copayment for a second opinion
• Physician home visits	$0 copayment for Physician home visit.
• 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	**Non-routine dental care: Based on place of service:** **(Requires provider preauthorization after initial visit)**

Services that are covered for you	**What you must pay** when you get these services
that would be covered when provided by a physician).	$0 copayment if emergent care provided in a Primary Care Physician's or Specialty Physician's office. 10% coinsurance if emergent care provided in an outpatient freestanding ambulatory surgical center facility or outpatient hospital. $0 copayment if emergent dental care provided in an urgent care center. $100 copayment if emergent dental care provided in an emergency room.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. Limit once every 60 days. • Routine foot care such as clipping of toe-nails or removal of corns and calluses 8 times per year	$0 copayment for Medicare-covered foot care in an office setting 10% coinsurance in a freestanding ambulatory surgical facility or outpatient hospital $0 copayment for 8 visits per year for routine foot care
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.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses	**(Certain items may require provider preauthorization)** 10% coinsurance for each external Medicare-covered standard prosthetic device.

Services that are covered for you	**What you must pay** when you get these services
(including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	$0 copayment for related supplies. $0 copayment to supplies related to Medicare-covered standard prosthetic devices. 10% 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 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 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
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 a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider	**(Certain services may require provider preauthorization)** $0 copayment for Medicare-covered services for kidney disease education self-dialysis training and home dialysis supplies and support. $0 copayment per treatment for outpatient dialysis treatments

Services that are covered for you	**What you must pay** when you get these services
for this service is temporarily unavailable or inaccessible)	
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	Inpatient dialysis treatments: See inpatient hospital for copayment
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for self-dialysis training
• Home dialysis equipment and supplies	10% coinsurance for home dialysis equipment and supplies
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	$0 copayment for certain home support services
• 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."	See Medicare Part B Drugs for Part B dialysis drugs. $0 copayment for Part B drugs
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 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.)	**(Requires provider preauthorization)** For Days 1 through 100: $0 copayment. No coverage for additional days over 100 for each benefit period. Covered up to 100 days per benefit period. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit

Services that are covered for you	**What you must pay** when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	period begins. There is no limit to the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. • <u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
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.	$0 copayment
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 36 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 will be coordinated through Independent Health's transportation coordinator. Call SafeRide at 877-593-3250 (TTY 711) Monday – Sunday 8:00 a.m. – 8:00 p.m. or contact Independent Health Member Services.

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services ***World-wide emergency/urgent coverage*** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.	$0 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:** Emergency: $100 copayment Urgent care: $0 copayment Ground Ambulance: $80 copayment Air Ambulance: 20% coinsurance Worldwide coverage: Maximum plan benefit limit of $10,000 per occurrence for unforeseen care coverage outside of the USA and its territories. Coverage ends when $10,000 limit is reached. Subject to a combined annual plan limit of $10,000.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **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.

[1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership.

Facilities and amenities vary by PL.

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 9, 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.
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care. (Care that helps with activities of daily living that does not require professional skills or training e.g. bathing and dressing.) 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**	
Home-delivered meals	**Not covered under any condition**	
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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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**	
Personal care assistant	**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**	
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.	**Not covered under any condition**	
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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care		• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). See Podiatry on the medical benefits chart in Chapter 4 for covered services.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		• Hearing aid evaluation exam and Hearing aids/fitting: Limited coverage through the Start Hearing 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 services 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).
- 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 Medicare Family Choice (HMO I-SNP) 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.
- 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 opted-out of 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 ben precluded of 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 12 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 A6531, A6532, A6534, A6535, and A6545 are limited to 6 pairs (12 individual stockings) per year cumulative total.
- Post Mastectomy Bras: Limited to 4 per year
- Electric Hospital Beds: A fully electric bed and accessories and parts is 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.
- 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, E & M codes and radiological services
- 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.
- 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).
- We do not cover services or programs in an Adult Day Care facility.

- 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.

Start Hearing - 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
- Costs associated with replacing lost or damaged hearing aids ($125 per hearing aid).
- Hearing aids other than select Starkey models purchased through a Start Hearing network provider.

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List*").
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's "Drug List."

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.independenthealth.com/Medicare), and/or call Member Services.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Pharmacy Directory*. You can also find information on our website at www.independenthealth.com/Medicare.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. See the Pharmacy Directory for pharmacies.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **Extended Day Supply (EDS) drugs** in our "Drug List."

Our plan's mail-order service requires you to order **up to a 90-day supply.**

To get information about filling your prescriptions by mail contact Independent Health's Member Services at the phone number listed on the back of this book.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail-order may be delayed. In which case you may need to ask your doctor to write another prescription for a 30-day supply to be filled at a network retail pharmacy. Your local retail pharmacy can contact our Pharmacy Help Desk for a one-time override.

First-time registration

Before using ProAct or Wegmans Mail Order Service for the first time, you will have to register with the mail order pharmacy of your choice. Here's how to register (Please have your member ID number available):

To register by mail: Please fill out the registration form for the mail order pharmacy of your choice. Forms are available by calling our Member Services number on the back of this booklet or online at www.independenthealth.com.

Or register online:

ProAct: secure.proactrx.com/mail-order/1
Wegmans Mail Order: www.Wegmans.com/Pharmacy

Or register by phone:

ProAct: 1-866-287-9885 (TTY: 711)
Wegmans Mail Order: 1-800-934-4797 (TTY: 711)

Obtaining Prescriptions

- You will first need a new prescription written by your doctor. Please ask your doctor to write a new prescription for a 90-day supply for mail order service plus refills for up to 1 year (as appropriate).
- **Please note:** When placing your initial order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 30-day supply to be filled at your local retail network pharmacy.
- Your copayment for your 90-day supply depends on your plan.
- You may easily pay your copayments using Visa, MasterCard, Discover, American Express, or by check or money order.

Ordering Refills

- You can easily refill your prescription online, by telephone or by mail. You will need to have your member ID number and your prescription number when ordering refills. If you choose to pay by credit card, please have that number available as well. To make sure you don't run out of medication, remember to reorder 14 days before your medication runs out. When using mail order pharmacies, your medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an additional charge).

  New prescriptions the pharmacy receives directly from your doctor's office. After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

Refills on mail order prescriptions. For refills, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's "Drug List." (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information).
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

How can you get a Vacation Supply of drugs?

- Independent Health will provide a one-time 30-day supply per calendar year for non-maintenance medications. On a case by case basis, exceptions will be made for additional vacation supplies as long as the member is in accordance with directions of use and does not have more than a 180-day supply of medication.
- Independent Health will provide a one-time override for a 3-month supply of a maintenance medication if the member has less than a 30-day supply on hand. On a case by case basis, exceptions will be made for additional vacation supplies as long as the member is in accordance with directions of use and does not have more than a 180-day supply of medication.
- You must permanently reside in our service area at least 6 months out of the contract year. 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.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area

where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the US, but outside of Independent Health's service area, and you become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at a non-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.
- Prior to filling your prescription at a non-network pharmacy, call Member Services at the number listed on the back cover to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, by contacting Member Services at the number listed on the back cover, we may be able to make arrangements for you to get your prescriptions from a non-network pharmacy.
- **We cannot pay for any prescriptions that are filled by pharmacies outside the United States (including in Canada), even for a medical emergency. This applies to cruise ships flying foreign flags.**

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the "Drug List" are only those covered under Medicare Part D.

We will generally cover a drug on the plan's "Drug List" as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our "Drug List" and in Medicare Plan Finder, along with the specific medical conditions that they cover.

The "Drug List" includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List," when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services (phone numbers are printed on the back cover of this booklet).

What is *not* on the "Drug List?"

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the "Drug List." For more information, please see Chapter 9.

Section 3.2 There are five cost-sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Preferred Generic: Consists of generic drugs. This is the lowest tier.
- Tier 2 – Generic: Consists of generic drugs.
- Tier 3 – Preferred Brand: Consists of brand drugs.
- Tier 4 – Non-Preferred Drug: Consists of brand and generic drugs.
- Tier 5 – Specialty Tier: Consists of specialty drugs, generic drugs, brand drugs. This is the highest tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's "Drug List."

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the "Drug List?"

You have three ways to find out:

1. Visit the plan's website (www.independenthealth.com/MedicareFormularies). The "Drug List" on the website is always the most current.
2. Call Member Services to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
3. Use the plan's "Real-Time Benefit Tool" (https://ih.changehealthcare.com/ or by calling Member Services). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition. You will have to log in to the Member Portal to access this tool, once logged in you can utilize this tool to estimate your cost of medications covered on the Independent Health formulary.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List." If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once on our "Drug List." This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider or interchangeable biosimilar has told us the medical reason that neither the generic drug interchangeable biosimilar nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the "Drug List" or if the drug is restricted in some way?

If your drug is not on the "Drug List" or is restricted, here are options:

- You may be able to get a temporary supply of the drug
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's "Drug List"** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan**.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90-days of the calendar year.
- This temporary supply will be for a maximum of 30 days supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30-days supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than *90 days* and reside in a long-term care facility and need a supply right away:**

  We will cover one 34-days emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply. In addition to the above transition policy, members who transfer from one treatment setting to another (i.e. LTC, ICF-MR, residential psychiatric centers, SNF etc.) within the plan year, will be allowed up to a 34-day transition supply.
  Please note that our transition policy only applies to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out-of-network access. See Section 4 for information about non-Part D drugs.

For questions about a temporary supply, call Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's "Drug List." Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The "Drug List" can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the "Drug List." For example, the plan might:

- **Add or remove drugs from the "Drug List."**
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's "Drug List."

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List," but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.

- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List." If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change and can work with you to find another drug for your condition.

- **Other changes to drugs on the "Drug List"**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the "Drug List" that do not affect you during this plan year

We may make certain changes to the "Drug List" that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the "Drug List."

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the

change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the "Drug List" for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. **Off-label** use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans (Our plan covers certain drugs through our enhanced drug coverage. More information is provided below.):

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Certain over-the-counter drugs are covered on Tier 2 of your prescription drug plan. Please see the plan's Drug List for a complete list of covered drugs and limitations. The amount you pay for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's "Drug List" or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6)]

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid medications from a certain doctor(s)
- Limiting the amount of opioid medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an

MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

CHAPTER 6:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services, and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Member Services.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing** and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered drugs, and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
    - The Initial Coverage Stage
    - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
    - Prescription drugs covered by Part A or Part B
    - Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Independent Health's Medicare Family Choice (HMO I-SNP) members?

There are four **drug payment stages** for your prescription drug coverage under Independent Health's Medicare Family Choice (HMO I-SNP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket, or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.

- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.

- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

SECTION 4 There is no deductible for Independent Health's Medicare Family Choice (HMO I-SNP)

There is no deductible for Independent Health's Medicare Family Choice (HMO I-SNP). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers

Every drug on the plan's "Drug List" is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1 – Preferred Generic**: Consists of generic drugs. This is the lowest tier.
- **Tier 2 – Generic**: Consists of generic drugs.
- **Tier 3 – Preferred brand**: Consists of brand drugs. You pay $0 per month supply of each covered insulin product on this tier.
- **Tier 4 – Non-preferred drug**: Consists of brand and generic drugs. You pay $0 per month supply of each covered insulin product on this tier.
- **Tier 5 – Specialty Tier**: Consists of specialty drugs, generic drugs, brand drugs. This is the highest Tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's "Drug List."

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 34-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost Sharing Tier 1 (Preferred Generic)	$4 copayment	Mail order is not available for drugs in Tier 1 for a 30-day supply	$4 copayment	$4 copayment
Cost Sharing Tier 2 (Generic)	$15 copayment	Mail order is not available for drugs in Tier 2 for a 30-day supply	$15 copayment	$15 copayment
Cost Sharing Tier 3 (Preferred Brand)	25% coinsurance	Mail order is not available for drugs in Tier 3 for a 30-day supply	25% coinsurance	25% coinsurance
Cost Sharing Tier 4 (Non-Preferred Drug)	25% coinsurance	Mail order is not available for drugs in Tier 4 for a 30-day supply	25% coinsurance	25% coinsurance
Cost Sharing Tier 5 (Specialty Tier)	33% coinsurance	Mail order is not available for drugs in Tier 5 for a 30-day supply	33% coinsurance	33% coinsurance

You won’t pay more than $0 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is a 100-day supply on Tier 1 and a 90-day supply on Tier 2, Tier 3 and Tier 4.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard retail cost sharing (in-network) (Up to a 100-day supply on Tier 1. Up to a 90-day supply on Tiers 2, 3, and 4.)	**Mail-order cost sharing** (Up to a 100-day supply on Tier 1. Up to a 90-day supply on Tiers 2, 3, and 4.)
Cost Sharing Tier 1 (Preferred Generic)	$10 Copay	$10 Copay
Cost Sharing Tier 2 (Generic)	$37.50 Copay	$37.50 Copay
Cost Sharing Tier 3 (Preferred Brand)	25% Coinsurance	25% Coinsurance
Cost Sharing Tier 4 (Non-Preferred Drug)	25% Coinsurance	25% Coinsurance
Cost Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

You won't pay more than $70 for up to a two-month supply or $87.50 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay, and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won’t pay more than $0 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
- For excluded drugs covered under our enhanced benefit, you pay your Tier 2 copay.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List". Our plan covers most adult Part D vaccines at no cost to you. Call Member Services for more information. Refer to your plan's "Drug List" or contact Member Services for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.

- For other Part D vaccines, you will pay the pharmacy your copayment or coinsurance for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment or coinsurance for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.

Note: To utilize Situation 3 you must receive prior consent from your Physician that s/he is willing to use a vaccine medication that you picked up from your pharmacy. Without prior consent from your Physician this option is not available for this plan.

CHAPTER 7:

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

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

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

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

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

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

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you 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 or drugs 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.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's "Drugs List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.
- Drugs purchased out-of-network. When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above ("How do you fill prescriptions outside the network?), the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Chapter 5.
- Drugs paid for in full when you don't have your membership card. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you don't have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Chapter 5.
- Drugs paid for in full in other situations. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Chapter 5.
- Drugs purchased at a better cash price. In rare circumstances when you are in a coverage gap and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.
- Copayments for drugs provided under a drug manufacturer patient assistance program. If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim

to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Member Services. Please include your receipt(s) with your written request.

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 9 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 either calling us or 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 claim to us within one year** of the date you received the service, item, or drug.

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:

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

For Part D Prescription Drug Claims:
Independent Health
PO Box 9066
Buffalo, NY 14231-9066
Attn: Pharmacy 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 or drug 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 or drug 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 or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug 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 right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, 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 9 of this document

CHAPTER 8:
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 and drugs

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. 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. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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 including information about your Part D prescription drugs. 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 by 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.

Independent Health's Privacy Notice

Effective April 14, 2003
Revised September 1, 2020

OUR PROMISE
At Independent Health, we recognize our responsibility to be diligent stewards of your personal information. We value the relationship we have with our members and are committed to protecting your information with administrative, technical, and physical safeguards to protect against unauthorized access as well as threats and hazards to its security and integrity. We take great care to safeguard your personal information using industry best practices. We also require these same standards of our business associates and vendors. Independent Health trains employees on a regular basis about the importance of protecting your personal information. We protect the privacy of your information in accordance with federal and state privacy and security laws and regulations such as the Health Insurance Portability and Accountability Act (HIPAA).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice covers the privacy practices of Independent Health Association, Inc. and Independent Health Benefits Corporation.

WHAT IS YOUR PERSONAL INFORMATION?
Personal information is any information about you received or created by Independent Health for the purpose of administering your health benefits. This includes any information that can identify you as an individual, such as your name, address and Social Security Number, as well as your financial, health, and other information.

HOW INDEPENDENT HEALTH USES AND DISCLOSES YOUR PERSONAL INFORMATION

In order to administer your health insurance, Independent Health uses and discloses your personal information to coordinate treatment with your doctors, pay for your care, and our health care operations. Under the law, we may perform these functions without your specific authorization or approval. When performing these functions, we only use or disclose the minimum amount of information necessary. These functions include:

- **Treatment.** We may disclose your personal information to your health care providers to help them provide medical care to you. Here are a few examples:
    - If you are in the hospital, we may give your doctor at the hospital access to medical or pharmacy records that we have. We may use your personal information to coordinate care.
    - To inform you of other health-related benefits, such as medical treatments, health-related products and services, or a description of our health plan or providers. For example, we might send you information about smoking cessation programs, weight loss programs, or prescription refill reminders.
- **Payment.** To help pay for your covered services, we may use and disclose your personal information. For example, we may use and disclose your personal information:
-
    - To pay your medical bills that your health care providers have submitted to us.
    - To conduct “utilization review” (which means deciding if a particular health care item or service is medically appropriate).
    - To coordinate benefits between our coverage and other insurers who may be fully or partially responsible for payments.
- **Health Care Operations.** We may use and disclose your personal information to others who help us conduct our health care operations. For example, we may disclose your personal information for the following purposes:
-
    - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating Independent Health.
    - Conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs.
- **Business Associates.** We may disclose your personal information to companies with whom we have contracted with if they need it to perform services we have requested. For example, we may disclose your personal information to become approved or accredited by an independent quality assurance entity called the National Committee for Quality Assurance (NCQA). We only will disclose your personal information to outside entities that agree to protect your personal information just as we would and we only transfer the

minimum information necessary to accomplish a task. We obtain a written agreement from every business associate and review their practices to ensure they are protecting your personal information just as we would.

USES AND DISCLOSURES REQUIRED BY LAW

We may use or disclose your personal information without your authorization when required by law:

- **For public health and disaster relief efforts**.
- **To regulatory bodies**, such as the United States Department of Health and Human Services (HHS), the New York State Department of Financial Services (DFS) and the New York State Department of Health (DOH).
- **To report public health activities**. For example, we may report to entities that track certain diseases such as cancer.
- **To a coroner or medical examiner** to help identify a deceased person, to determine a cause of death, or as authorized by law. We may also disclose your personal information to a funeral director as necessary to carry out their duties.
- **To public health agencies in order to avoid harm**. For example, we may report your personal information to a government authority if we believe there is a serious health or safety threat to you or others, or in cases of child abuse, neglect or domestic violence.
- **For health oversight activities**, such as audits, inspections, licensure and disciplinary actions.
- **To meet legal requirements**. For example, in response to a court ordered subpoena.
- **For law enforcement activities**. For example, we may disclose personal information to identify or locate a suspect, fugitive, material witness or missing person, to report a crime or to provide information about crime victims.
- **For specific government functions**, such as military and veteran activities, national security and intelligence activities, and providing protective services to the President.
- **For workers' compensation purposes**.

OTHER USES AND DISCLOSURES

We may also use or disclose your personal information without your authorization in the following miscellaneous circumstances:

- **For certain employer-sponsored group health plans**. If you are enrolled in Independent Health because of your work and your employer has adopted certain privacy procedures, we may communicate with your employer to fulfill certain administrative requirements. Most often though, we will only disclose enrollment and disenrollment information and summary health information (i.e., aggregate data not including any of your identifiers like

name, address, etc.) to your employer or any broker acting on your employer's behalf. Please ask your employer for more details.

- **For purposes of organ donation**, such as for procurement, banking or transplantation of organs, eyes, or tissue.
- **For research**. If we use or disclose your personal information for a research project that contributes to knowledge generally, we take steps to keep your information private and secure. In some instances, we may have a research review board approve the procedures we have put in place to secure your personal information. If we do not receive approval from a research review board, we will ask for your authorization before we use or disclose your personal information for research.
- **For fundraising**. We may use or disclose your personal information to raise funds for our business or for our related foundation, the Independent Health Foundation. If we do contact you to raise funds, we will provide you with an opportunity to opt out of future fundraising communications. If you chose to opt out, we will honor your decision and will not use your personal information for fundraising.
- **For underwriting**. Independent Health may receive your personal information for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, such as premium computations, contribution amounts, or application of preexisting condition exclusions (collectively "underwriting"). If we received your personal information for an underwriting purpose and you become an Independent Health member, we will only use or disclose your personal information in accordance with this notice and applicable law. If you do not become an Independent Health member, we will only use your personal information we received for underwriting, unless we are required by law to use it for another purpose. We will not use the genetic information for underwriting or prior to or in connection with your enrollment. Genetic information means information about your genetic tests (for example, analysis of human DNA, RNA or chromosomes) or the genetic tests of your family members, the manifestation of disease or disorder in your family members (for example, a family medical history) or any request of or receipt by you or your family members of genetic tests, genetic counseling or genetic education. The term genetic information does not include sex or age information. If you are pregnant, the term genetic information includes genetic information concerning the fetus. If you use reproductive technology, the term genetic information includes genetic information about an embryo.
- **If your personal information has been de-identified**. "De-identifying" information means removing all parts of your information that could identify you. HIPAA gives us rules to follow when "de-identifying" your personal information and permits us to disclose de-identified information without your authorization.

SPECIAL CONSIDERATIONS

Either State or Federal law contain important limitations on how we can disclose your personal health information pertaining to HIV/Aids, mental health, alcohol and substance abuse, sexually transmitted diseases, pregnancy/reproductive, and genetic testing. For those conditions, we follow rigorous standards that provide heightened privacy protections to you. These additional standards are designed to give you added security and confidence regarding our handling of such information while still allowing you to obtain needed medical treatment freely and without hesitation.

USES AND DISCLOSURES WE WILL NOT MAKE

Even though permitted by law, we will not use and disclose your personal information for the following reasons:

- **Sale**. We will not sell your personal information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

If we disclose your information for a reason that does not fit in one of the general categories listed above, we must obtain your written permission. This written permission is called an "authorization." Here are examples of instances when **we must ask for your permission** before disclosing your personal information:

- If you consult an attorney and your attorney needs your personal information in order to represent you.
- If anyone other than you or a doctor who is treating you asks us to disclose your personal information.
- If we use your personal information to market an outside company's product or service and we receive financial payment from the outside company for making the communication. However, we may send you refill reminders and communications about treatment, health-related products or services that are included in your plan, case management, and governmental programs (such as Medicaid managed care) without asking for your authorization first.

If you give us written permission and then change your mind about that permission, you may take back or revoke your written permission at any time, except if we have already acted based on your permission. If you have questions or would like to obtain a copy of our authorization form, please call our toll-free Member Services number on your ID card or on the back cover of this book. Monday through Friday from 8 a.m. to 8 p.m., or e-mail us at memberservice@servicing.independenthealth.com.

WHEN YOU ASK US FOR PERSONAL INFORMATION ABOUT OTHERS

If you request your family members' personal information, **we may need to obtain written permission from that family member**. Here are some examples:

- If you call and ask for specific information about your spouse's medical claims, such as a list of their pharmacy claims, we will ask for your spouse's written permission before disclosing any information to you.
- If you are a parent and ask for personal information about your son or daughter who is on your health insurance policy, but who is 18 or over, we will need to get your son or daughter's written permission before disclosing their information to you.
- If you ask us for information about a health care item or service that your minor child can obtain without your parental consent, such as outpatient mental health treatment, we will ask for your child's written permission before disclosing that information to you.

If you have questions, please call our toll-free Member Services number on your ID card, or on the back cover of this book. Monday through Friday from 8 a.m. to 8 p.m., or e-mail us at memberservice@servicing.independenthealth.com.

YOUR RIGHTS REGARDING YOUR PERSONAL INFORMATION

By law, you have several important rights with respect to your personal information. You may exercise any of the rights described below, or ask any questions about these rights by calling our toll-free Member Services number on your ID card, Monday through Friday from 8 a.m. to 8 p.m., or e-mail us at memberservice@servicing.independenthealth.com.

- **You have the right to ask us to restrict** how we use, or disclose your personal information for treatment, payment, or health care operations. You may also ask that we limit the information we give to others who are involved in your health care or payment for your health care such as a family member or a friend. Your request may be received verbally or in writing. Please note that we will accommodate reasonable restriction requests. If we do agree, we will honor your request unless it is an emergency situation.
- **You have the right to ask us to communicate with you by a different method or in a different manner.** For example, if you believe that you would be harmed if we send your personal information to your current mailing address (situations involving domestic disputes), you may ask us to send your personal information by fax instead of mail or to a P.O. Box instead of your home address. We will agree to reasonable requests.
- **You have the right to request a copy** of your personal information in your designated record set, including an electronic copy in many cases. You also have the right to inspect your personal information in your designated record set. A "designated record set" is a group of records that is used by or for us to make decisions about you. We may ask you to

request copies of your personal information in writing and to specify the information you are requesting. We also may charge a reasonable fee for copying and mailing your personal information. We will respond to your request no later than 30 days after we receive it. If we are unable to act within the 30 days, we may extend that time by no more than an additional 30 days. In certain situations, we may deny your request, or part of your request, but we will tell you why we are denying your request. You have the right to ask for a review of that denial.

- **You have the right to ask us to make changes** to your personal information we maintain about you in your "designated record set" if you believe it is wrong or if information is missing. This is called the right "to amend" your personal information. Your request may be verbal or in writing, but you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within the 60 days, we may extend that time by no more than an additional 30 days. If we make the change, we will notify you that it was made. In some cases, we may deny your request to change your personal information. For example, we may deny your request if we did not create the information you want changed. If we deny your request, we will notify you in writing about the reason for the denial. The denial will explain your right to file a written statement of disagreement. These statements will be filed with the record you asked us to change.
- **You have the right to ask for an accounting of disclosures** we have made for reasons other than treatment, payment and health care operations. You have the right to receive a maximum of six (6) years' worth of disclosures in your accounting. Your request for an accounting must be in writing and specify the information requested. We will act on your request within 60 days, unless we need an additional 30 days.
- **You have the right to receive an electronic or paper copy of this notice**.
- **You have the right and will receive notice about any breaches** of your personal information in accordance with applicable state and federal laws.
- **You have the right to file a complaint** if you believe your privacy rights have been violated or if you disagree with a decision we made about your access to your personal information. We will not take any action against you for filing a complaint. You may contact us with your complaint by calling, writing, or e-mailing Independent Health's Information Risk Office at:

Information Risk Office
Independent Health
511 Farber Lakes Drive
Buffalo, New York 14221
(716) 631-3001 or 1-800-247-1466
(TTY users call: 711)
memberservice@servicing.independenthealth.com

You could also contact the United States Department of Health and Human Services (HHS).

OUR OBLIGATION

We are required by law to maintain the privacy of your personal health information, give you notice of our legal duties and privacy practices, notify you following a breach of your personal information, and to follow the terms of the notice currently in effect. We may change the terms of this notice at any time. The revised notice will apply to any personal information we maintain. Once revised, we will give you the new notice by United States mail and will post it on our website.

QUESTIONS

If you have any questions about this notice or about how we use or disclose your personal information, please contact Independent Health's Information Risk Office at (716) 631-3001 or 1-800-247-1466. Our Information Risk Office is open Monday through Friday from 9 a.m. to 5 p.m. (TTY users: 711). You can also contact us by e-mail at memberservice@servicing.independenthealth.com.

HOW INDEPENDENT HEALTH PROTECTS YOUR PERSONAL FINANCIAL INFORMATION

Most information we obtain about you relates to your health. However, your personal information could contain information that is financial in nature. We may obtain personal financial information about you from the following sources:

- Information received from you on applications or other forms such as your name, address, social security number, and telephone number;
- Information about your transactions with us, our affiliates or others, such as your premium payment history, enrollment history, type of health insurance coverage, medical claims history, and coordination of benefits information; and
- Information about you from other sources, such as your employer or a hospital or medical facility you have visited.

Independent Health does not sell your personal financial information for any reason. We do not disclose your personal financial information, except as required by law and in order to perform treatment, payment and health care operations.

Translation statement
Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request. (Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.)

Rights and Responsibilities

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

- Call Member Services at the number on the back cover of this booklet.
- Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Chapter 2 and on the back cover of this booklet.
- Visit www.medicare.gov/ to view or download the publication "Your Medicare Rights & Protections."
- Call 1-800-MEDICARE (1-800-633-4227). TDD users should call 1-877-486-2048, 24 hours a day/ 7 days a week.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health or drug benefits that are available to you**.**

- **You are required to tell our Plan if you have additional health insurance or drug coverage. Call Member Services.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.
- Paying your plan premiums and coinsurance/co-payment/coinsurance or co-payment for your covered services. You must pay for services that aren’t covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, 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 on line 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.

Family Choice of New York (FCNY) Model of Care for Independent Health’s Medicare Family Choice (HMO I-SNP) plan.

Special Needs Plans are required to have a Model of Care that describes specifically how we provide services to meet the unique needs of our members.

I. Purpose and Objectives of the Model of Care

The purpose of Family Choice Care Management Program is to coordinate care to members across time and setting and to assure that care is appropriate.

The objectives of Family Choice Model of Care are:

- To assess all members’ risk of developing serious medical conditions.
- Based on initial and ongoing assessments, to provide early intervention whenever possible.

- To assure that the care delivered is appropriate for the age, health care wishes and health status of the member.
- To identify medical problems as early as possible so that, to the greatest extent possible, further decline, unnecessary hospitalization and futile treatment are avoided.
- To communicate frequently with providers, members, families, caregivers and/or facility staff in order to effectively coordinate care to members.
- To monitor the use of resources so that care is effective, efficient and appropriate.
- To capture all encounter and outcome data for measurement against performance thresholds as established in the Quality Management Program.

II. Key Elements of the Model of Care

A. The Interdisciplinary Care Team

The Interdisciplinary Care Team consists of the member's Primary Care Provider (PCP), FCNY Nurse Practitioner (NP) or Physician Assistant (PA), FCNY Social Worker/Care Manager, FCNY Transition Nurse, FCNY Medical Director and the member or their representative. Based on the member's needs identified in the Health Risk Assessment and during frequent member visits and contacts, other disciplines may be added to the team as needed. These include but are not limited to: physical, occupational or speech therapist, behavioral health specialist, and medical specialist.

The Interdisciplinary Care Team is responsible for the planning, delivery and coordination of care to members across time and setting. Their individual roles and responsibilities are:

1. PCP
   - Visits every 30-60 days by regulation and more frequently as necessary, or as requested by the Nurse Practitioner or Physician Assistant
   - Provides medical oversight of the member's care
   - Provides consultation to the Nurse Practitioner or Physician Assistant on patient care issues
2. Family Choice Nurse Practitioner or Physician Assistant
   - Coordinates the activities of the Interdisciplinary Care Team
   - Visits members as medically necessary to prevent the decline in health and to avoid unnecessary hospitalization or outpatient procedures.
   - Communicates regularly with facility staff and primary care provider to keep them informed of the member's condition and needs.
   - Contacts the member's family at least once each month
   - Establishes and maintains collaborative relationships with facility staff.

- Conducts assessments, plan interventions, write orders.
- Identifies the need for social service intervention with family members, responsible party and facility staff to provide education and support.
- Provides education to facility staff as requested and necessary.
- A program Nurse Practitioner or Physician Assistant is on-call 24/7 to respond to member care needs.

3. Transition Nurse

- Support members and their families when the member experiences a transition to another care setting such as admission to the hospital.
- Tracks the status of the member while they are in the hospital or other care setting and informs the Interdisciplinary Care Team.
- Provides members and/or their families with information about the transition process as needed.

4. Program Social Worker/Care Manager:

- Assists members and their families/responsible parties with psychosocial issues impacting the members care, functional status or quality of life.
- Assists with care coordination, completion of the health risk assessment, and development of an Individualized Care Plan to meet your needs.
- Provides psychosocial interventions as needed or refers member to a community resource.

5. Program Nurse *(Assisted Living Facilities only)*

- Assist with coordination of the interdisciplinary team to meet member needs

B. The Assessment Process

Within 90 days of enrollment, within 14 business days of discharge following a hospital admission, and annually thereafter a member of the Interdisciplinary Care Team, conducts a full health risk assessment of the member and, based on the results of that assessment, develops an Individualized Care Plan to meet the members' specific needs. The Nurse Practitioner or Physician Assistant performs a History and Physical upon enrollment, within two business days of the plan's notification of a transition between care settings and annually.

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 Medicare Family Choice (HMO I-SNP), 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 and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies 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. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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 of 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.
- **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 9 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* 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.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **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 pay your plan premiums.
  - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.

  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **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 9:

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, or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

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

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to

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 10** 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 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 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.independenthealth.com/Medicare.)
    - 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.

  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call 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.pdfor on our website at www.independenthealth.com/Medicare.) 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 within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** 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 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to 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 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 7 and 8 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 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - 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 days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

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

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

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

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 days or 7 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 60 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.** We are allowed to charge a fee for copying and sending this information to you.

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 10 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

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

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

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**. We are allowed to charge you a fee for copying and sending you this information.
- 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 9 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 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is 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 for our share of the cost within 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 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we

generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term "Drug list" instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our "Drug List."** If we agree to cover a drug not on the "Drug List," you will need to pay the cost-sharing amount that applies to Tier 4. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List." If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug List" is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

    - If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You cannot ask us to change the cost-sharing tier for any drug in Tier 5 - Speciality Tier.
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our "Drug List" includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

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

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber'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 or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a 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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form or on our plan's form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **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. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **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. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **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. We will also tell you how you can appeal.

<u>Step 4:</u> If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you are going to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

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

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 1-800-665-1502 or 716-250-4401. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **The appeal form is available online and can be submitted electronically via a secure email.**
  www.independenthealth.com/IndividualsFamilies/Medicare/MedicareMemberResources/ComplaintsandAppeals
- **You must make your appeal request within 60 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 in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

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

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.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar** days after we receive your request.
- **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. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **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 drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: 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 on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged 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 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two 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:

    - 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 the 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 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 7.2 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 State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care

for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **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,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

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 7.3 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

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

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

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

Step-by-Step: How to make a Level 1 *Alternate* appeal

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

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

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

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

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

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

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

Step-by-Step: Level 2 *Alternate* appeal Process

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

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan 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: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *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 8.2 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 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 8.3 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 State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

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 for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

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

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

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

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

Step-by-Step: How to make a Level 1 *Alternate* appeal

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

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

- **Ask for a fast review**. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review

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

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

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

Step-by-Step: Level 2 Alternate appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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.

- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 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.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug 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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal 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 answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

Section 10.1 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, pharmacists, 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, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

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 or drugs 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 10.2 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 10.3 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 and/or Part D Prescription Drugs Grievances** (for complaints about Part C medical care or services and/or Part D Prescription Drugs) in Section 8. 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: Appeals and Complaints, 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 Complains 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 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 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 10.4 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 10.5 You can also tell Medicare about your complaint

You can submit a complaint about Independent Health's Medicare Family Choice (HMO I-SNP) 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 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Independent Health's Medicare Family Choice (HMO I-SNP) 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 prescription drugs 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 at any time

You can end your membership in Independent Health's Medicare Family Choice (HMO I-SNP) at any time

- Because you live in a nursing home, you can end your membership in *[insert 2023 plan name]* at any time.
- 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.
- Original Medicare *without* a separate Medicare prescription drug plan.

    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

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

Section 2.2 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 2024*** 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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• 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 Medicare Family Choice (HMO I-SNP) when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled**.
- **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 Medicare Family Choice (HMO I-SNP) 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 Medicare Family Choice (HMO I-SNP) 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.
- You do not meet the plan's special eligibility requirements as stated in Chapter 1, Section 2.1
    - You will have a 30 day deeming period. If you do not meet the plan's special eligibility requirements within the 30 days of deemed continued eligibility you

will be disenrolled for the first of the month after the 30 days of deemed continued eligibility.

- If you change or move your residence from a participating nursing or assisted facility to a non-participating nursing or assisted living facility, you no longer meet special eligibility requirements.
- Or, if you no longer require an institutional level of care defined by New York State regulation, you no longer meet special eligibility requirements

- 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 lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
  - We must notify you in writing that you have *90 days* to pay the plan premium before we end your membership.
  - The grace period begins when the individual has been notified of (billed for) the actual premium amount due, with such notice/bill specifying the due date for that amount.
  - You must pay the past due amount in full to be removed from the payment delinquency process.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

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 Medicare Family Choice (HMO I-SNP) 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 11:
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 Medicare Family Choice (HMO I-SNP), 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 12:
Definitions of important words

Chapter 12. 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 prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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 Medicare Family Choice (HMO I-SNP), 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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 or prescription drugs

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered

under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

Diagnostic screening - a service or test used to diagnose or treat an illness, disease, or injury. Member liability applies as outlined in Chapter 4 of this booklet.

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

"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.

Formulary - (See list of covered drugs).

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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

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

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

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

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

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

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

Inpatient Care – Health care that you get when you are admitted to a hospital.

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

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

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.

Late Enrollment Penalty – The late enrollment penalty is an amount that may be added to a person's monthly Part D premium. A person enrolled in a Medicare drug plan may owe a late enrollment penalty if he or she goes without Part D or creditable prescription drug coverage for any continuous period of 63 days or more after the end of his or her Initial Enrollment Period for Part D coverage. Generally, the late enrollment penalty (also called the "LEP" or "penalty") is added to the person's monthly Part D premium for as long as he or she has Medicare prescription drug coverage, even if the person changes his or her Medicare drug plan. The late enrollment penalty amount changes each year. The cost of the late enrollment penalty depends on how long the person went without Part D or creditable prescription drug coverage.

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.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

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, Medicare Part A and Part B premiums, and prescription drugs 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. See Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.

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 Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

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

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

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. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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 Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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 or drugs 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.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on

average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Preauthorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

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.

Prior Authorization – Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

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

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

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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.

State Pharmaceutical Assistance Program (SPAP) – New York State offers NYS EPIC (Elderly Pharmaceutical Insurance Coverage). EPIC provides secondary coverage for Medicare Part D and EPIC-covered drugs purchased after any Medicare Part D deductible is met. EPIC also covers approved Part D-excluded drugs once a member is enrolled in Part D.

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 are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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 – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

INDEPENDENT HEALTH'S

Medicare Advantage Provider Directories and Prescription Drug Formularies

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.

Independent Health

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.

Y0042_C8408_C_1

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 http://www.hhs.gov/ocr/office/file/index.html.

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 1-800-665-1502번으로 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 ा या दवा की योजना के बारे म आपके किसी भी के जवाब देने के लिए हमारे पास मु दुभाषिया सेवाएँ उपल ह. एक दुभाषिया ा करने के लिए, बस हम 1-800-665-1502 पर फोन कर. कोई जो हि ी बोलता है आपकी मदद कर सकता है. यह एक मु 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's Medicare Family Choice (HMO I-SNP) 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 requires special telephone equipment and 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

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