**January 1 – December 31, 2026**

# Evidence of Coverage for 2026:

**Your Medicare Health Benefits and Services and Drug Coverage as a Member of Independent Health's Medicare Passport Connect (PPO)**

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

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

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

**For questions about this document, call Member Services 1-800-665-1502 or 716-250-4401 (TTY users 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 Passport Connect (PPO), is offered by Independent Health Benefits Corporation (When this *Evidence of Coverage* says "we," "us," or "our," it means Independent Health Benefits Corporation. When it says "plan" or "our plan," it means Independent Health's Medicare Passport Connect (PPO).)

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 copayment/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

# 2026 Evidence of Coverage

## Table of Contents

# CHAPTER 1:
# Get started as a member

## SECTION 1 You're a member of Independent Health's Medicare Passport Connect (PPO)

### Section 1.1 You're enrolled in Independent Health's Medicare Passport Connect (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, Independent Health's Medicare Passport Connect (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Independent Health's Medicare Passport Connect (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

### Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Independent Health's Medicare Passport Connect (PPO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (formulary)*, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Independent Health's Medicare Passport Connect (PPO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Independent Health's Medicare Passport Connect (PPO) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

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

## SECTION 2 Plan eligibility requirements

### Section 2.1 Eligibility requirements

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

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

### Section 2.2 Plan service area for Independent Health's Medicare Passport Connect (PPO)

Independent Health's Medicare Passport Connect (PPO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

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

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services 1-800-665-1502 or 716-250-4401 (TTY users call 711). to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

### Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Independent Health's Medicare Passport Connect (PPO) if you're not eligible to stay a member of our plan on this basis. Independent Health's Medicare Passport Connect (PPO) must disenroll you if you don't meet this requirement.

## SECTION 3 Important membership materials

### Section 3.1 Our plan membership card

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


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

If our plan membership card is damaged, lost, or stolen, call Member Services 1-800-665-1502 or 716-250-4401 (TTY users call 711) right away and we'll 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.

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

If you don't have a Provider Directory, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-665-1502 or 716-250-4401 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 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
- LIBERTY Dental Plan Dental Directory
- EyeMed "Insight" 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* https://www.independenthealth.com/DrugList lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the Pharmacy Directory to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at 1-800-665-1502 or 716-250-4401 (TTY users call 711). You can also find this information on our website at www.independenthealth.com/DrugList.

### Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Independent Health's Medicare Passport Connect (PPO). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Independent Health's Medicare Passport Connect (PPO) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit the plan's website (www.independenthealth.com/DrugList) or call Member Services at 1-800-665-1502 or 716-250-4401 (TTY users call 711). Your Drug list is called "Independent Health's Medicare Advantage 2026 Standard Part D Formulary".

## SECTION 4 Summary of Important Costs for 2026

| | **Your cost in 2026 (next year)** |
|---|---|
| **Monthly plan premium*** <br> *Your premium can be higher or lower than this amount. Go to Section 1.1for details. | **$58.80** |
| **Maximum out-of-pocket amount** <br> This is the most you'll pay out of pocket for covered Part A and Part B services. <br> (Go to Section 1.2for details.) | **From network providers:** <br> **$9,250** <br> **From network and out-of-network providers combined:** <br> **$13,900** |
| **Primary care office visits** | **In-Network** <br> **Primary care visits:** <br> **Tier A PCP - $0 copayment per visit** <br> **Tier B PCP - $20 copayment per visit** <br> **Out-of-Network** <br> **$175 Deductible applies, then** <br> **Primary care visits:** <br> **50% Coinsurance per visit** |

| | Your cost in 2026 (next year) |
|---|---|
| **Specialist office visits** | **In-Network**<br>**Specialist visits:**<br>**$55 copayment per visit**<br><br>**Out-of-Network**<br>**$175 Deductible applies, then**<br>**Specialist visits:**<br>**50% Coinsurance per visit** |
| **Inpatient hospital stays**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. | **In-Network:**<br>**Tier A facility:**<br>**$375 copayment per day, Days 1-6**<br>**$0 copayment per day,**<br>**Days 7+, per benefit period.**<br>**Unlimited days for Medicare covered stays.**<br>**$2,250 annual copayment maximum applies**<br>**Tier B facility:**<br>**$550 copayment per day,**<br>**Days 1-4**<br>**$0 copayment per day, Days 5+, per benefit period.**<br>**Unlimited days for Medicare covered stays.**<br>**$2,445 annual copayment maximum applies** |

| | **Your cost in 2026 (next year)** |
|---|---|
| | **Out-of-Network:**<br>**$175 deductible, then 50% coinsurance per admission.** |
| **Part D drug coverage deductible**<br>(Go to Section 1.3 for details.) | **$615 on all Drug Tiers** |
| **Part D drug coverage**<br>(Go to Section 1.4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | **Copayment/Coinsurance during the Initial Coverage Stage:**<br>**Drug Tier 1: 25%**<br>**Drug Tier 2: 25%**<br>**Drug Tier 3: 25%**<br>**Drug Tier 4: 25%**<br>**Drug Tier 5: 25%**<br>**Catastrophic Coverage Stage:**<br>**During this payment stage, you pay nothing for your covered Part D drugs.** |

Your costs can 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)
- Medicare Prescription Payment Plan Amount (Section 4.5)

### Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2026, the monthly premium for Independent Health's Medicare Passport Connect (PPO) is $58.80.

If you *already* get 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, call Member Services at 1-800-665-1502 or 716-250-4401 (TTY users call 711), and ask for the *LIS Rider.*

**In some situations, our 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. Learn more about these programs in Chapter 2, Section 7. If you qualify, enrolling in one of these program might lower your monthly plan premium.

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

### Section 4.2 Monthly Medicare Part B Premium

**Many members are required to pay other Medicare premiums**

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

### 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 was a period of 63 days or more in a row when you didn't 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 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'll 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 Passport Connect (PPO), we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You don’t have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare’s standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren’t creditable prescription drug coverage.

**Medicare determines the amount of the Part D late enrollment penalty.** Here’s 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, our plan will count the number of full months you didn’t have coverage. The penalty is 1% for every month you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.45. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You’ll continue to pay a penalty** every month for as long as you’re enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you’re *under* 65 and enrolled in Medicare, 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 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 ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

**Important:** Don't 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 our 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 (IRMAA).The extra charge is calculated 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 www.Medicare.gov/health-drug-plans/part-d/basics/costs..

If you have to pay an extra IRMAA, 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 our 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'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA you'll be disenrolled from our plan and lose prescription drug coverage.**

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

### Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

## SECTION 5 More information about your monthly plan premium

### Section 5.1 How to pay our plan premium

There are 4 ways you can pay our plan premium.

**Option 1: Pay 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 Road, 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 account, or charged directly to your credit card. Automatic deductions can occur monthly and it is recommended that these are set up to pull between the 1st and the 7th day of the month to avoid receiving a delinquent letter. 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: Have plan premium deducted from your monthly Social Security check**

You can have the 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 are printed on the back of this booklet.)

If you decide to change how pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you’re still responsible for making sure your is paid on time. To change your payment method, call Member Services at the phone numbers on the back of this booklet.

**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/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 2026. Upon confirmation, the DOH will send Independent Health the first EPIC payment for 2026. However, until we start receiving your EPIC payments for 2026, 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 2025 until early 2026. If you remain with Independent Health next year, those payments would be applied to your monthly plan premium for the first few months of 2027. As a result, there will be no gap in us receiving payments from EPIC in 2026. If you choose not to stay with Independent Health, we would refund those subsidy payments when we receive them in 2026.

**If you have trouble paying your plan premium**

Your plan premium is due in our office by the first day of the month. If we don't get your payment by the first day of the month, we'll send you a notice letting you know our plan membership will end if we don't get your plan premium within 90 days. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium on time, contact Member Services 1-800-665-1502 or 716-250-4401 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay your plan premium, you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D 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. If you want to enroll again in our plan (or another plan that we offer) in the future, you'll need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control and that made you unable to pay your within our grace period, you can make a complaint. For complaints we'll review our decision again. Go to Chapter 9 to learn how to make a complaint, or call us at 1-800-665-1502 or (716) 250-4401 from October 1 and March 31: Monday – Sunday, 8 a.m. – 8 p.m. and April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

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

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

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

## SECTION 6 Keep our plan membership record up to date

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

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

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

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so)

If any of this information changes, let us know by calling Member Services at 1-800-665-1502 (TTY users call 711).

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

## SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-665-1502 or 716-250-4401 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer"), pays up to the limits of its coverage. The insurance that pays second (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all 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) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

# CHAPTER 2: Phone numbers and resources

## SECTION 1 Independent Health's Medicare Passport Connect (PPO) contacts

For help with claims, billing, or member card questions, call or write to Independent Health's Medicare Passport Connect (PPO) Member Services 1-800-665-1502 (TTY users call 711). We'll be happy to help you.

| Member Services – Contact Information | |
|---|---|
| **Call** | **1-800-665-1502 or 716-250-4401**<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br>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.<br>Member Services 1-800-665-1502 (TTY users call 711) also has free language interpreter services for non-English speakers. |
| **TTY** | **711**<br>This number is only for people who have difficulties hearing or speaking.<br>Calls to this number are free.<br>October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. |
| **Fax** | **716-631-1039** |
| **Write** | 511 Farber Lakes Drive, Buffalo, NY 14221<br>medicareservice@servicing.independenthealth.com |
| **Website** | www.independenthealth.com/Medicare |

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

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

| Coverage Decisions and Appeals for Medical Care or Part D drugs – Contact Information | |
|---|---|
| **Call** | **1-800-665-1502 or 716-250-4401**<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br>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**<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. |
| **Fax** | **716-635-3504**<br>Pharmacy Coverage Determinations Fax: 716-631-9636 |
| **Write** | Part D Coverage Determination: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221<br>Medical Coverage Determinations: Independent Health Appeals and Complaints, PO Box 2090, Buffalo, NY 14231<br>email: Appeals@independenthealth.com |
| **Website** | www.independenthealth.com/Medicare |

### How to make a complaint about your medical care

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 doesn't

involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

| Complaints about Medical Care – Contact Information | |
|---|---|
| **Call** | **1-800-665-1502 or 716-250-4401**<br><br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br><br>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**<br><br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br><br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>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<br><br>email: Appeals@independenthealth.com |
| **Medicare website** | To submit a complaint about Independent Health's Medicare Passport Connect (PPO) directly to Medicare, go to www.Medicare.gov/my/medicare-complaint. |

### How to ask us to pay our share of the cost for medical care or a drug you got

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

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

| Payment Requests | Contact Information |
|---|---|
| **Call** | **1-800-665-1502 or 716-250-4401**<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br>Calls to this number are free. |
| **TTY** | **711**<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. |
| **Fax** | **716-635-3855** |
| **Write** | **For Medical Claims:**<br>Independent Health<br>Attn: Claims Department<br>PO Box 9066<br>Buffalo, NY 14231-9066<br><br>**For Part D drugs:**<br>Independent Health<br>PO Box 9066<br>Buffalo, NY 14231-9066<br>Attn: Pharmacy Department<br><br>**For Dental Claims:**<br>LIBERTY Dental Plan<br>P.O. Box 15149<br>Tampa, FL 33684<br><br>**For Vision Claims:**<br>EyeMed Vision Care<br>Attn: OON Claims<br>P.O. Box 8504<br>Mason, OH 45040-7111 |
| **Website** | www.independenthealth.com |

## SECTION 2 Get help from Medicare

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

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

| Complaints about Medical Care – Contact Information | |
|---|---|
| **Call** | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free.<br>24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free. |
| **Chat Live** | Chat live at www.Medicare.gov/talk-to-someone. |
| **Write** | Write to Medicare at PO Box 1270, Lawrence, KS 66044 |

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

## SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

| Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York's SHIP) – Contact Information | |
|---|---|
| **Call** | HIICAP Hot Line: 1-800-701-0501 |
| **TTY** | 711 |
| **Write** | Health Insurance Information, Counseling, and Assistance Program<br>New York State Office for the Aging<br>2 Empire State Plaza<br>Albany, New York 12223-1251<br>NYSOFA@aging.ny.gov |
| **Website** | www.aging.ny.gov |

| HIICAP Local Offices | |
|---|---|
| **Allegany County**<br>Office for the Aging<br>Anita Mattison, Director<br>6085 Route 19 N<br>Belmont, NY 14813<br>585-268-9390 | **Genesee County**<br>Office for the Aging<br>Ruth Spink, Director<br>Batavia-Genesee Senior Center<br>2 Bank Street<br>Batavia, NY 14020-2299<br>585-343-1611 |
| **Cattaraugus County**<br>Department of the Aging<br>Catherine M. Mackay, Director<br>One Leo Moss Drive, Suite 7610<br>Olean, NY 14760-1101<br>716-373-8032 | **Niagara County**<br>Office for the Aging<br>Darlene DiCarlo, Director<br>111 Main Street, Suite 101<br>Lockport, NY 14094-3718<br>716-438-4020 |
| **Chautauqua County**<br>Office for the Aging<br>Dr. Mary Ann Spanos, Director<br>7 North Erie Street<br>Mayville, NY 14757<br>716-753-4471 | **Orleans County**<br>Office for the Aging<br>Melissa Blanar, Director<br>County Administration Building<br>14016 Route 31W<br>Albion, NY 14411-9382<br>585-589-3193 |
| **Erie County**<br>Department of Senior Services<br>Mr. David Shenk, Commissioner<br>95 Franklin Street, Room 1329<br>Buffalo, NY 14202-3985<br>716-858-8526 | **Wyoming County**<br>Office for the Aging<br>Angela Aldinger, Deputy Director<br>8 Perry Avenue<br>Warsaw, NY 14569<br>585-786-8833 |

## SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For New York, the Quality Improvement Organization is called Commence Health (Formerly Livanta).

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

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

| Commence Health (New York's Quality Improvement Organization) – Contact Information | |
|---|---|
| **Call** | 1-866-815-5440 |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | BFCC-QIO Program<br>Commence Health<br>PO Box 2687<br>Virginia Beach, VA 23450 |
| **Website** | https://www.livantaqio.cms.gov/en |

## SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for 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, contact Social Security to let them know.

| Social Security – Contact Information | |
|---|---|
| **Call** | 1-800-772-1213<br>Calls to this number are free.<br>Available 8 am to 7 pm, Monday through Friday.<br>Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | 1-800-325-0778<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br>Available 8 am to 7 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. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact the Department of Social Services.

| 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<br>Corning Tower<br>Empire State Plaza,<br>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**<br>Allegany County DSS<br>7 Court Street<br>County Office Building, Rm. 127<br>Belmont, New York 14813-1077<br>(585) 268-9622 | **Genesee County**<br>Genesee County DSS<br>5130 East Main Street<br>Batavia, New York 14020<br>(585) 344-2580 |
| **Cattaraugus County (Main Office)**<br>Cattaraugus County DSS<br>Cattaraugus County Building<br>1 Leo Moss Drive, Suite 6010<br>Olean, New York 14760-1158<br>(716) 373-8065 | **Niagara County**<br>Niagara County DSS<br>20 East Avenue<br>PO Box 506<br>Lockport, New York 14095-0506<br>(716) 439-7600 |
| **Chautauqua County**<br>Chautauqua County DSS<br>3 N. Erie St.<br>Hall R. Clothier Building<br>Mayville, New York 14757<br>(716)753-4000 | **Orleans County**<br>Orleans County DSS<br>14016 Route 31 West<br>Albion, New York 14411-9365<br>(585) 589-7000 |
| **Erie County**<br>Erie County DSS<br>Edward A. Rath County Office Building<br>95 Franklin Street, 8th Floor<br>Buffalo, New York 14202-3959<br>(716) 858-8000 | **Wyoming County**<br>Wyoming County DSS<br>466 North Main Street<br>Warsaw, New York 14569-1080<br>(585) 786-8900 |

## SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

**Extra Help from Medicare**

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with 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.<br><br>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.<br><br>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.<br><br>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 get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 1-800-665-1502 (TTY users call 711) if you have questions.

### What if you have Extra Help and coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

### What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help 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 in your state, people 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, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the New York State Department of Health/ADAP (www.health.ny.gov/diseases/aids/general/resources/adap/eligiblity.html).

| ADAP New York State Department of Health – Contact Information | |
|---|---|
| **Call** | **1-800-542-2437**<br>TTY: 711 |
| **Write** | New York State Department of Health (NYDOH)<br>Uninsured Care Programs<br>Empire Station<br>P.O. Box 2052<br>Albany, NY 12220-0052<br>adap@health.state.ny.us |
| **Website** | www.health.ny.gov<br>(www.health.ny.gov/diseases/aids) |

### State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help 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).**

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

**Medicare Prescription Payment Plan**

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member Services at 1-800-665-1502 (TTY users call 711) or visit www.Medicare.gov.

| Medicare Prescription Payment Plan – Contact Information | |
|---|---|
| **Call** | 1-800-665-1502 or 716-250-4401<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br>Member Services 1-800-665-1502 (TTY users call 711) also has free language interpreter services for non-English speakers. |

| Medicare Prescription Payment Plan – Contact Information | |
|---|---|
| **TTY** | **711**<br>This number is only for people who have difficulties hearing or speaking.<br>Calls to this number are free.<br>Hours of operation (Eastern time):<br>October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. |
| **Fax** | 716-631-1039 |
| **Write** | 511 Farber Lakes Drive, Buffalo, NY 14221<br>medicareservice@servicing.independenthealth.com |
| **Website** | www.independenthealth.com |

## SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

| Railroad Retirement Board (RRB) – Contact Information | |
|---|---|
| **Call** | 1-877-772-5772<br>Calls to this number are free.<br>Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.<br>Press "1" to access the automated RRB Helpline and get recorded information 24 hours a day, including weekends and holidays. |
| **TTY** | 1-312-751-4701<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number aren't free. |
| **Website** | https://RRB.gov |

## SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services 1-800-665-1502 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

# CHAPTER 3:
# Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

### Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services. Our provider network has two tiers. If you use a Tier A provider or facility for certain services, your cost share will be lower than if you use a Tier B provider or facility. See the Chapter 4 Benefit Chart for more details.
- **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 Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, Independent Health's Medicare Passport Connect (PPO) must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

Independent Health's Medicare Passport Connect (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.

- **The care you get 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 get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider Directory* www.independenthealth.com.
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - Because our plan is a Regional Preferred Provider Organization, if there isn't a network provider available for you to see, you can go to an out-of-network provider but still pay the in-network amounts.
    - Note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

## SECTION 2 Use network and out-of-network providers to get medical care

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

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

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

### How to choose a PCP

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

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.

You can also seek care out-of-area from any out-of-network provider who participates with Medicare. These providers are not listed in the directory. You will pay a higher cost sharing for out-of-network providers.

Some providers have additional hospital coverage arrangements for hospitals that may not be listed in the directory. Please make sure to check with your provider prior to scheduling your hospital admission to ensure that they are admitting you to a covered In-Network hospital (that is offered in your plan).

The most up-to-date directory is on our website under the "Find A Doctor" search tool (www.independenthealth.com/IndividualsFamilies/FindADoctor). You can also ask member services to assist you or send you a *Physician/Provider Directory* (phone numbers are printed on the back cover of this booklet).

### How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP or you'll pay more for covered services. If you choose an in-network PCP, you will have a lower copay.

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 under the member "Log In" and complete the registration process by entering your information.

## Section 2.2 Medical care you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's the service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never exceed the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that is outside our plan's network, your cost sharing can't exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is available and you choose to get services inside the service area from a provider outside our plan's network, the cost sharing for the dialysis may be higher. If possible, let us know before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

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

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

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

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.

Independent Health's Medicare Passport Connect (PPO) includes access to out-of-state providers through our partnership with the national MultiPlan Medicare Advantage Network. At these providers, your plan works the same as in-network, giving you the same great coverage on benefits and services when you travel outside of Independent Health's service area.

Visit www.independenthealth.com/medicare before your visit to make sure the provider is in the MultiPlan Medicare Advantage Network or call Member Services. If you choose not to see a MultiPlan Medicare Advantage Network provider you will have to pay your out-of-network cost share, which may be higher.

**When a specialist or another network provider leaves our plan**

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

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

unavailable or inadequate to meet your medical needs. You must obtain authorization from the plan's Medical Directory prior to seeking care. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

- If you find out that your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

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

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 9, Section 4). This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

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

### Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, 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's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're 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 receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.
- **As soon as possible, make sure 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 our Independent Health membership card. The phone number is also on the back cover of this book.

#### Covered services in a medical emergency

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

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

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

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

**What if it wasn't a medical emergency?**

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

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

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

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

- If you can't reach your Primary Care Physician, call our 24-hour Medical Help Line: 1-800-665-1502 (TTY users: 711).
  Access to experienced registered nurses 24 hours a day, 7 days a week for non-emergency medical issues and advice and Treatment Decision Support.
- You can receive urgent care from an urgent care center or walk-in clinic.
- Use our web tool to locate an urgent care center near you www.independenthealth.com/Medicare.
- Find an urgent care center via our mobile app. To download the app to your smartphone, visit www.independenthealth.com/MobileAppMyIH.
- Our plan covers emergency/urgent services world-wide but does not cover routine care outside of the United States.

**Independent Health's Telemedicine Program:**

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

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

- Cold and flu symptoms
- Bronchitis
- Allergies
- Poison ivy
- Eye Infections/Pink eye
- Respiratory infection
- Strep Throat
- Sinus problems
- Behavioral health services

Consultation Access:

- You create an account online. You have the option of requesting a phone or video consultation.
- Account creation involves completing baseline health information such as providing a medical history, allergy information, list of medications, health problems, family history and Primary Care Physician contact information.
- A U.S. board-certified physician will review your electronic health record, then will contact you to discuss health care concerns.
- The physician recommends the appropriate treatment for your medical issue. If necessary, the doctor may prescribe medication for your diagnosis. Prescriptions for short-term antibiotics, antihistamines or anti-bacterial agents can be sent to your preferred pharmacy. Nearly all of the drugs prescribed are generic. Teladoc

does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse.

- The prescription is sent to a pharmacy of your choice following the consultation.
- Your credit card is charged the applicable cost sharing and a receipt for services is provided upon request. (See Chapter 6 for your prescription drug cost sharing information).
- The physician updates your electronic health record based upon the consult.
- At the end of the consultation you are asked if you would like your information forwarded to your PCP; based on your approval the information is then forwarded to your PCP.
- The service is available 24/7 and may be accessed if traveling throughout the U.S and anywhere in the world where there is internet access.
- We also offer Teladoc via a smart phone or tablet app anywhere in the world where there is internet access. Download the app from www.teladoc.com/ih to your smart phone or tablet, create your account and you'll have access to a doctor from your home state from most places in the world, including on cruise ships, within 60 minutes. If you have already created your account, you can access Global Care through it. If it is appropriate for your health condition, a prescription recommendation will be sent to you that you can take to a pharmacy. There is a CMS regulation that prohibits Independent Health or Medicare from covering the cost of any Part D prescription drug when it's purchased outside of the United States or its' territories.

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

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

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

### Section 3.3 Get care during a disaster

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

Visit www.independenthealth.com/Medicare Resources for information on how to get needed care during a disaster.

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

during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

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

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

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

Independent Health's Medicare Passport Connect (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're 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 use up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will count toward an out-of-pocket maximum.

## SECTION 5 Medical services in a clinical research study

### Section 5.1 What is a clinical research study

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

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

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

device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

### Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.

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

**Get more information about joining a clinical research study**

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

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

### Section 6.1 A religious non-medical health care institution

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

### Section 6.2 How to get care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
- – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

## SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Independent Health's Medicare Passport Connect (PPO), you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you after 10 months. Call Member Services at 1-800-665-1502 (TTY users call 711)

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

## Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Independent Health's Medicare Passport Connect (PPO) 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 Passport Connect (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you’re still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you’re again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

# CHAPTER 4:
# Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Independent Health's Medicare Passport Connect (PPO). This section also gives information about medical services that aren't covered and it also explains limits on certain services.

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

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

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our plan deductible.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

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

### Section 1.2 Our plan deductible

**Your deductible is $175 and is combined for in-network and out-of-network services.** Until you've paid the deductible amount, you must pay the full cost for most of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible doesn't apply to some services, including certain in-network and out-of-network preventive services. This means that we pay our share of the costs for these services

even if you haven't paid your deductible yet. The deductible only applies to these services in-network:

Outpatient Hospital Services

The deductible applies to all Medicare-covered diagnostic and treatment services out-of-network. See the Chapter 4 Benefit Chart for details.

### Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

Your **in-network maximum out-of-pocket amount** is $9,250. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D drugs, and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are listed in the first row of the Medical Benefits Chart.) If you pay $9,250 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Your **combined maximum out-of-pocket amount** is $13,900. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are listed in the first row of the Medical Benefits Chart.) If you pay $13,900 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

### Section 1.4 Our plan also limits your out-of-pocket costs for certain types of services

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

Our plan has two annual out-of-pocket maximums for covered Inpatient Hospital care, based on the type of facility you use. For care received at **Tier A facilities**, the out-of-pocket maximum is **$2,250**. For care received at **Tier B facilities**, the out-of-pocket maximum is **$2,445**. Once you've paid the applicable out-of-pocket maximum, our plan will cover covered Inpatient Hospital care at no cost to you for the rest of the calendar year.

Amounts you pay for Inpatient Hospital care at either Tier A or Tier B facilities **count toward both** maximums. However, the plan begins covering your Inpatient Hospital care in full **only once you've reached the out-of-pocket maximum for the tier where the service is received.** For example, if you receive care at a Tier B facility, you must reach the $2,445 maximum (even if you've already paid $2,250 at a Tier A facility).

Both the maximum out-of-pocket amount for Part A and Part B medical services and the tier-specific out-of-pocket maximums for Inpatient Hospital care apply to your coverage. This means that once you've paid either **$9,250 in-network or $13,900 for in-network and out-of-network** Part A and Part B medical services or the applicable **$2,250 (Tier A)** or **$2,445 (Tier B)** for Inpatient Hospital care, your Inpatient Hospital care will be covered at no cost to you for the rest of the year. The Medical Benefits Chart shows the service category out-of-pocket maximums.

### Section1.5 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:

  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Member Services at 1-800-665-1502 (TTY users call 711).

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

The Medical Benefits Chart on the next pages lists the services Independent Health's Medicare Passport Connect (PPO) covers and what you pay out of pocket for each service (Part D drug coverage is covered in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization)
  - Covered services that need approval in advance to be covered as in-network services are marked Requires Provider Preauthorization in bold in the Medical Benefits Chart.

  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.govor ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

**You 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

| Covered Service | What you pay |
|---|---|
| **Annual Out of Pocket Maximum** | In-network cost sharing is limited to a $9,250 in-network maximum per year or $13,900 combined in-and-out-of-network out-of-pocket maximum per year. The in-network cost sharing applies to both the in-network limit and out-of-network limit. However, the out-of-network cost sharing limit only applies to Medicare-covered out-of-network services.<br>Premiums, optical dispensing, routine eyewear cost in excess of annual limit, routine/preventive dental, comprehensive dental services, Medicare Part D prescription drugs, hearing aid evaluation exam, and hearing aids do NOT count towards the out of pocket maximum. Costs incurred for services outside of the USA are not included in the out of pocket maximum. |
| **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors | **In-Network:**<br>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.<br>**Out-of-Network:** |

| Covered Service | What you pay |
|---|---|
| and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist | 50% coinsurance |
| **Acupuncture for chronic low back pain**<br>Covered services include:<br>Up to 12 visits in 90 days are covered under the following circumstances:<br>For the purpose of this benefit, chronic low back pain is defined as:<br>• lasting 12 weeks or longer;<br>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.);<br>• not associated with surgery; and<br>• not associated with pregnancy.<br>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br>Treatment must be discontinued if the patient is not improving or is regressing.<br>**Provider Requirements:**<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.<br>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: | **In-Network:**<br>$55 copayment per visit<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance per visit |

| Covered Service | What you pay |
|---|---|
| • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• 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.<br>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**<br>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. | **(Provider preauthorization is required for planned transportation only in-network.)**<br>**In-Network:**<br>$265 copayment for each Medicare-covered service or one-way trip by ground transportation<br>20% coinsurance for Medicare-covered air transportation<br>Copayment applies for evaluation, treatment or transportation to the hospital for each Medicare-covered service or one-way trip.<br>The copayment is NOT waived even if you are admitted to a hospital as an inpatient immediately following the ambulance transport.<br>Wheelchair van, stretcher van and ambulette transportation are not covered. |

| Covered Service | What you pay |
|---|---|
| | **Out-of-Network:**<br>$175 deductible applies, then:<br>$265 copayment for each Medicare-covered service or one-way trip by ground transportation.<br>20% coinsurance for Medicare-covered air transportation.<br>Copayment applies for evaluation, treatment or transportation to the hospital for each Medicare-covered service or one-way trip.<br>The copayment is NOT waived even if you are admitted to a hospital as an inpatient immediately following the ambulance transport.<br>Wheelchair van, stretcher van and ambulette transportation are not covered.<br>**Outside United States and its territories:**<br>Worldwide coverage: Deductible does not apply. Maximum plan benefit limit of $10,000. The $10,000 plan limit is per occurrence for the combined unforeseen event outside of the United States and its territories. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share.<br>Plan deductible does not apply. |
| **Annual wellness visit** | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the annual wellness visit.<br>The annual wellness visit cannot be performed by an OB/GYN |

| Covered Service | What you pay |
|---|---|
| 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.<br><br>**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. | **Out-of-Network:**<br><br>50% coinsurance in a Primary Care Physician's office<br><br>50% coinsurance in a Specialty Physician's office. |
| **Enhanced Annual Physical Exam**<br><br>(Also known as the "Enhanced Annual Visit" EAV). As a member of our Plan, you can receive an annual "Enhanced Annual Visit" also referred to as an "EAV". **You can receive an annual EAV one (1) time per calendar year from a qualified physician or qualified non-physician practitioner. Once you have the EAV performed during the plan calendar year, the benefit is exhausted.** If you change your primary care physician (PCP) during the plan year, another EAV is not covered and you may be liable for the cost of the service. Our Medicare plans require you to choose a primary care physician (PCP) who will provide most of your care and arrange/coordinate the covered services you get as a member of our Plan including the EAV. Only your chosen PCP currently on record with Independent Health can perform and bill for the annual EAV. See Chapter 3 of your Evidence of Coverage to see what types of providers may act as a PCP and provide the EAV. | **In-Network:**<br><br>$0 copayment from your Primary Care Provider<br><br>**Out-of-Network:**<br><br>Not Covered |

| Covered Service | What you pay |
|---|---|
| The EAV is a supplemental benefit that includes services beyond an Annual Wellness Visit. The EAV includes a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all the body systems as well as a full examination to assess your overall general health and detect any abnormalities or signs that could indicate a disease process that should be addressed. The visit may also include the completion of a Health Risk Assessment and a discussion regarding potential gaps in care that need to be addressed to meet your individual needs.<br><br>If your Primary Care Provider is not able to perform the EAV or you are unable to obtain an EAV, please contact Independent Health and we will assist with scheduling a convenient in-home EAV on your provider's behalf. OB/GYN's are not eligible to perform the EAV. | |
|  **Bone mass measurement**<br>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office. |

| Covered Service | What you pay |
|---|---|
| | Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialist Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance in a Primary Care Physician's office.<br><br>50% coinsurance in a Specialty Physician's office. |
| **Breast cancer screening (mammograms)**<br><br>Covered services include:<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for women aged 40 and older<br>• Clinical breast exams once every 24 months | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.<br><br>**Out-of-Network:**<br><br>50% coinsurance for Medicare-covered screening mammograms<br><br>3D tomography imaging is covered in full if part of the preventive screening. |
| **Cardiac rehabilitation services**<br><br>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.<br><br>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.<br><br>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 | Limited to 36 visits per occurrence.<br><br>**In-Network:**<br><br>$0 copayment for Medicare-covered cardiac rehabilitation services.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance |

| Covered Service | What you pay |
|---|---|
| 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. | |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**<br>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>50% coinsurance for the intensive behavioral therapy cardiovascular disease preventive benefit in a Physician's office. |
| **Cardiovascular disease screening tests**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | **In-Network:**<br>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.<br>**Out-of-Network:** |

| Covered Service | What you pay |
|---|---|
| | 50% coinsurance for cardiovascular disease testing that is covered once every 5 years. |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• For all women: Pap tests and pelvic exams are covered once every 24 months<br>• If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months | **In-Network:**<br>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>50% coinsurance for Medicare-covered preventive pap and pelvic exams. |
| **Chiropractic services**<br>Covered services include:<br>• Manual manipulation of the spine to correct subluxation<br>• We cover certain non-Medicare covered Evaluation and Management services above and beyond subluxation of the spine. Covered services are the evaluation of a new or existing patient with low to moderate complexity and medical decision making to assess a member's condition and create or modify a plan of care. | **In-Network:**<br>$15 copayment per visit for covered services.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance per visit for Medicare-covered chiropractic services. |

| Covered Service | What you pay |
|---|---|
| **Chronic pain management and treatment services**<br>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. | Cost sharing for this service will vary depending on individual services provided under the course of treatment. |
|  **Colorectal cancer screening**<br>The following screening tests are covered:<br>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which cost share applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.<br>Separate office visit cost sharing may apply (i.e., pre and post procedure consultations):<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office. |

| Covered Service | What you pay |
|---|---|
| • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.<br>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema.<br>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years.<br>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. | Tier B PCP: $20 copayment in a Primary Care Physician’s office.<br><br>$55 copayment in a Specialty Physician’s office.<br><br>Barium Enema: $55 copayment<br><br>**Out-of-Network:**<br><br>50% coinsurance for a Medicare-covered colorectal cancer screening exam.<br><br>Serum (blood testing) colorectal cancer screening has a 50% coinsurance.<br><br>Barium Enema: $175 deductible applies, then 50% coinsurance. |

| Covered Service | What you pay |
|---|---|
| • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. | |
| **Dental services**<br><br>**Medicare covered Dental**<br><br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:<br><br>**Dental from a LIBERTY Dental Plan provider:**<br><br>**Limitations:**<br><br>**<u>Routine Preventive:</u>**<br><br>• Oral Exams are limited to 2 every year.<br>• Routine Cleanings are limited to 2 every year.<br>• Fluoride treatments are limited to 2 every year.<br>• Bitewing x-rays are limited to twice in any calendar year. | **Medicare Covered Dental:**<br><br>**(Non-routine dental care requires provider preauthorization after initial visit.)**<br><br>**In-Network:**<br><br>Cost share based on place of service. See Non-Medical Dental in Physician/Practitioner Services of the Chapter 4 Benefits Chart.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance for Medicare-covered dental services by a Specialist.<br><br>**In-Network and Out-of-Network:**<br><br>$1,500 annual plan benefit maximum per year for routine, preventive and comprehensive dental services. Once the annual plan benefit maximum is met, additional dental services are not covered.<br><br>**Routine Preventive**<br><br>**In-Network:**<br><br>$0 copayment for each visit for routine preventive dental (see limitations in left hand column) at participating LIBERTY Dental Plan providers in Independent Health's Medicare LIBERTY Dental Plan dental network.<br><br>**Out-of-Network:** |

| Covered Service | What you pay |
|---|---|
| • Full mouth x-rays are limited to once every 36 months.<br><br>**Comprehensive Dental:**<br><br>Covers additional dental services, for example:<br><br>Periodontal cleaning<br>Crowns<br>Dentures<br>Extractions<br><br>See Section 3.1 of this chapter (LIBERTY Dental Plan Exclusions) for a complete list of covered services.<br><br>Routine preventive and comprehensive dental benefit is administered by LIBERTY Dental Plan.<br><br>For claims, eligibility and benefit questions, call our Member Services department toll-free at 1-888-352-7811. TTY users call 1-877-855-8039. Member Services representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Standard Time).<br><br>**LIBERTY Dental Plan**<br><br>P.O. Box 15149<br>Tampa, FL 33684<br><br>Website: www.libertydentalplan.com<br><br>**Scheduling Appointments**<br><br>After you have selected a LIBERTY Dental Plan dentist, call the dentist's office to schedule an appointment. Tell the dentist you are covered by LIBERTY Dental Plan's network for Independent Health's Medicare Advantage plans and ask the | If you visit a dentist that is not in our dental network you will pay a $0 copayment. You will be covered up to the In-Network contractual payment amount for out-of-network services. Balance billing may apply.<br><br>If you paid for out-of-network services up front, you will need to submit a claim form for reimbursement. Claim forms are available at www.independenthealth.com/medicare.<br><br>**Comprehensive**<br><br>**In-Network:**<br><br>Comprehensive Dental Services are subject to $0 deductible and 50% coinsurance on covered services.<br><br>**Out-of-Network:**<br><br>If you visit a dentist that is not in our dental network you will pay a 50% coinsurance. You will be covered up to the In-Network contractual payment amount for out-of-network services. Balance billing may apply.<br><br>Member cannot combine any promotional offers with our dental benefit.<br><br>If you paid for out-of-network services up front, you will need to submit a claim form for reimbursement. Claim forms are available at www.independenthealth.com/medicare.<br><br>**Enrollee Liabilities**<br><br>You must pay for any non-covered or optional dental services that you choose to have done. This program is designed to cover diagnostic and preventive dental treatment that is consistent with good |

| Covered Service | What you pay |
|---|---|
| dentist to confirm that he or she is a participating provider in the network. | professional practice. You will be responsible for services you receive that are not covered benefits as listed in this EOC and services received that are greater than the limits specified in this EOC.<br><br>To find a network dental provider, see our LIBERTY Dental Plan Dental Directory at independenthealth.com/Medicare or contact member services at the number on the back of this book.<br><br>Member cannot combine any promotional offers with our dental benefit. |
| **Depression screening**<br><br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for an annual depression screening visit.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>Tier A specialist: $55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance for an annual depression screening visit in a Primary Care Physician's office. |
| **Diabetes screening** | **In-Network:** |

| Covered Service | What you pay |
|---|---|
| We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.<br><br>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test. | There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance for the Medicare-covered diabetes screening tests.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>50% coinsurance in a Primary Care Physician's office<br><br>50% coinsurance in a Specialty Physician's office. |
| **Diabetes self-management training, diabetic services and supplies** | **(Certain items require provider preauthorization in-network.)** |

| Covered Service | What you pay |
|---|---|
| For all people who have diabetes (insulin and non-insulin users). Covered services include:<br><br>• Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. | Supplies used with the administration of insulin are covered under your Part D prescription drug benefit (i.e., syringes).<br><br>For Omni-pod coverage please reference your formulary by visiting www.independenthealth.com/medicare<br><br>Diabetic glucose meters and supplies are limited to Abbott Freestyle and Precision meters and testing supplies<br><br>**In-Network:**<br><br>Covered in full for blood glucose monitor.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance for blood glucose monitor and devices.<br><br>**In-Network:**<br><br>$0 copayment per item for each 30-day supply of test strips. Limit 100 test strips per 30-day period.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance for test strips<br><br>Limit 100 test strips per 30-day period. |

| Covered Service | What you pay |
|---|---|
| • Continuous glucose monitor and supplies | **In-Network:**<br>$0 copayment for each Medicare-covered lancet.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered lancet.<br>**(Requires provider preauthorization)**<br>**In-Network:**<br>Continuous glucose monitors and supplies requires provider preauthorization. Limited to preferred providers.<br>$0 copayment for therapeutic continuous glucose monitors and supplies. Limited to preferred continuous glucose monitors and supplies.<br>20% coinsurance for nontherapeutic continuous glucose monitor and supplies to only be obtained at a network pharmacy. Limited to preferred continuous glucose monitors and supplies.<br>These are no longer covered through medical supply or durable medical equipment providers and only covered through network pharmacies.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for continuous glucose monitor and supplies.<br>Limited to preferred continuous glucose monitors and supplies. |
| • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts | **In-Network:**<br>$0 copayment for Medicare-covered therapeutic custom-molded shoes and inserts as listed in left column. |

| Covered Service | What you pay |
|---|---|
| provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. | **Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered therapeutic custom-molded shoes and inserts as listed in left column. |
| • Diabetes self-management training is covered under certain conditions. | **In-Network:**<br>Covered in full for diabetes self-management training.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician’s office.<br>Tier B PCP: $20 copayment in a Primary Care Physician’s office.<br>$55 copayment in a Specialty Physician’s office.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition: |

| Covered Service | What you pay |
|---|---|
| | $175 deductible applies, then 50% coinsurance in a Primary Care Physician's office<br><br>$175 deductible applies, then 50% coinsurance in a Specialty Physician's office. |
| **Durable medical equipment (DME) and related supplies**<br><br>(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3)<br><br>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.<br><br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.independenthealth.com/Medicare. | **(Certain items require provider preauthorization in-network.)**<br><br>**In-Network:**<br><br>10% coinsurance for certain Medicare-covered items from preferred DME provider, People First Mobility.<br><br>20% coinsurance for Medicare-covered DME items.<br><br>For a list of covered items, see the chart at the end of this table.<br><br>For certain mobility devices, contact People First Mobility.<br><br>Phone: 716-566-5000<br>Fax: 716-877-1371<br>Address: 800 Hertel Ave., Suite 103 Buffalo, NY 14207<br>Email: contact@peoplefirstmobility.net<br>Website: www.peoplefirstmobility.net<br><br>Please see Section 3.1 of this chapter for additional information on DME coverage.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance for each Medicare-covered DME item.<br><br>**In-Network:** |

| Covered Service | What you pay |
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| | Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month for 36 months.<br>No copay will apply for the remainder of the 5-year reasonable useful lifetime of the equipment (month 37 through 60).<br>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 the next 36 months.<br>If prior to enrolling in Independent Health's Medicare Passport Connect (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Independent Health's Medicare Passport Connect (PPO) is 20% coinsurance.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for oxygen equipment.<br>Please see section 3.1 of this chapter for additional information on DME coverage. |
| **Emergency care**<br>**Worldwide Emergency/Urgent Coverage**<br>Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a | **In-Network:**<br>$115 copayment per Emergency room visit within or outside the service area.<br>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.<br>ER copayment is waived if admitted during the current visit. If the member leaves the facility and returns, and is then admitted, they will owe the ER copayment for the first ER visit, but the second ER visit copayment is waived upon admission. |

| Covered Service | What you pay |
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| pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.<br><br>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. | The copayment is waived if you are transferred to another emergency room because the first location cannot treat your condition.<br><br>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.<br><br>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.<br><br>**Out-of-Network:**<br><br>$115 copayment per Emergency room visit within or outside the service area.<br><br>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.<br><br>ER copayment is waived if admitted during the current visit. If the member leaves the facility and returns, and is then admitted, they will owe the ER copayment for the first ER visit, but the second ER visit copayment is waived upon admission.<br><br>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. |

| Covered Service | What you pay |
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| | 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.<br><br>**Outside United States and its territories:**<br><br>Worldwide coverage: Deductible does not apply. Maximum plan benefit limit of $10,000. The $10,000 plan limit is per occurrence for the combined unforeseen event outside of the USA. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share.<br><br>Plan deductible does not apply. |
|  **Health and wellness education programs**<br><br>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.<br><br>• **Medicare HealthStyles Newsletter** Once annually, Independent Health publishes a member newsletter, which includes articles, tips and other information aimed at keeping members healthy.<br>• **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. | **In-Network:**<br><br>$20 copayment for certain community health education classes.<br><br>$0 copayment for all other Health and Wellness education programs.<br><br>**Out-of-Network:**<br><br>Not covered |

| Covered Service | What you pay |
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| • **Health and Wellness Classes** Certain classes offered by community providers which address a variety of health related topics.<br>• **Health Education: 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.<br>• **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.<br>• Additional Case Management Services, including frail elderly and palliative care, are available to assist members with complex care needs, who are discharged from the hospital and/or living at home with | |

| Covered Service | What you pay |
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| declining physical functioning relating to chronic and serious illnesses. These services provide support and linkage to resources to optimize a member's independence and comfort. Members may request a case management evaluation by calling member services and ask to speak with the Case Management Department. The phone number is on the back cover of this book and on your Member ID card. | |
| • **Fitness Benefit:** | **In-Network:**<br>SilverSneakers®<br>$0 copayment.<br>SilverSneakers gives you FREE access to:<br>• Thousands of participating fitness center locations nationwide[1]<br>• SilverSneakers Live classes and workshops taught by instructors trained in senior fitness<br>• 200+ workout videos in the SilverSneakers On-Demand™ online library<br>• SilverSneakers GO™ mobile app with digital workout programs<br>• Burnalong®access with a supportive virtual community and thousands of classes for all interests and abilities<br>• GetSetUp, with hundreds of interactive online classes one hour or less, ranging from nutrition to mindfulness and more. |

| Covered Service | What you pay |
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| | 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 Customer Service at 800-665-1502 or 716-250-4401 (TTY: 711)<br>**Out-of-Network:**<br>You must use a participating facility that offers SilverSneakers. Thousands of facilities nationwide.<br>Memberships will not roll over plan year to plan year. Memberships will restart on January 1st of each year.<br>Benefit may change on January 1st of each year. |
| **Hearing services**<br>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.<br>• Routine hearing exams | **In-Network:**<br>Tier A PCP: $0 copayment in a Primary Care Physician's office for a Medicare covered or routine hearing exam.<br>$55 copayment in a Specialty Physician's office for a Medicare covered or routine hearing exam.<br>**Out-of-Network:**<br>$175 deductible applies for Medicare-covered hearing exams. 50% coinsurance for a Medicare covered or routine hearing exam. |

| Covered Service | What you pay |
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| • Hearing aids evaluation exam to see if you need a hearing aid.<br>• Benefit is limited to preferred hearing aids through a provider in the Start Hearing network, which come in various styles and colors.<br><br>Hearing Aid purchase includes:<br>o Fittings for hearing aids: 6 provider visits for fitting and evaluation within the first year of hearing aid purchase<br>o 60 day trial purchase<br>o 2 year extended warranty for each hearing aid priced at $499<br>o 3 year extended warranty for each hearing aid priced at $699, $999, $1,499 or $1,949.<br>o Rechargeable and non-rechargeable models available.<br>o Non-rechargeable models include 40 batteries per hearing aid<br>o Loss and damage warranty claims ($250 each hearing aid)<br><br>Benefit does not include or cover any of the following:<br>o Ear molds<br>o Hearing Aid accessories<br>o Additional provider visits<br>o Extra batteries<br>o Hearing aids that are not through a provider in the Start Hearing network | **In-Network:**<br><br>$45 copayment per exam for a fitting and evaluation hearing aid exam from a provider in the Start Hearing network.<br><br>Copayment Structure per hearing aid: $499, $699, $999, $1,499, or $1,949.<br><br>$250 allowance towards member cost share per ear per year.<br><br>Benefit is limited to preferred hearing aids, which come in various styles and colors. You must see a network provider to use this benefit.<br><br>You MUST use a provider in the Start Hearing network for this benefit.<br><br>Hearing aid evaluation exam and hearing aid copayments are not subject to the out-of-pocket maximum.<br><br>Member cannot combine any promotional offers with our hearing aid benefit.<br><br>**Out-of-Network**:<br>You must use a provider in the Start Hearing network. Available nationwide.<br>Member cannot combine any promotional offers with our hearing benefit. |

| Covered Service | What you pay |
|---|---|
| **Costs associated with excluded items are the responsibility of the member and not covered by the plan.** | |
| **HIV screening**<br>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:<br>• One screening exam every 12 months<br>If you are pregnant, we cover:<br>• Up to 3 screening exams during a pregnancy | **In-Network:**<br>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>50% coinsurance for members eligible for Medicare-covered preventive HIV screening.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>$175 deductible applies, then 50% coinsurance in a Primary Care Physician's office.<br>$175 deductible applies, then 50% coinsurance in a Specialty Physician's office. |

| Covered Service | What you pay |
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| **Home health agency care**<br>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but aren't limited to:<br>• 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)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services | **Provider preauthorization required for in-home Physical Therapy, Occupational Therapy or Speech Therapy**<br>**In-Network:**<br>$0 copayment for Home Health agency care<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Home Health agency care. |
| • Medical equipment and supplies | **In-Network:**<br>Medical supplies are covered in full when medically necessary.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for medical supplies.<br>**(Provider preauthorization may apply for some equipment in-network.)**<br>**In-Network:**<br>10% coinsurance - 20% coinsurance for Medicare-covered medical equipment (DME). See Durable Medical Equipment in this benefit chart for more details.<br>**Out-of-Network:** |

| Covered Service | What you pay |
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| | $175 deductible applies, then 50% coinsurance for Medicare-covered medical equipment (DME). |
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<br><br>Covered services include, but aren't limited to:<br>• Professional services, including nursing services, furnished in accordance with our plan of care<br>• Patient training and education not otherwise covered under the durable medical equipment benefit<br>• Remote monitoring<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | **In-Network:**<br>$0 copayment<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance<br><br>See Medicare Part B Drugs for Home Infusion Drug cost sharing. |
| **Hospice care**<br>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs | **In-Network:**<br>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 Passport Connect (PPO).<br>**Out-of-Network:**<br>Must be a Medicare-certified Hospice |

| Covered Service | What you pay |
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| in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br><br>Covered services include:<br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care<br><br>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.<br><br>**For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.<br><br>**For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). | |

| Covered Service | What you pay |
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| • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services<br>• If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare<br><br>**For services covered by *Independent Health's Medicare Passport Connect (PPO)* but not covered by Medicare Part A or B:** *Independent Health's Medicare Passport Connect (PPO).* will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.<br><br>**For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4).<br><br>**Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.<br><br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | **In-Network:**<br><br>Office visit copayment may apply for hospice consultation services:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office. |

| Covered Service | What you pay |
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| | Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then office visit copayment may apply for hospice consultation services:<br><br>50% coinsurance in a Primary Care Physician's office.<br><br>50% coinsurance in a Specialty Physician's office. |
| **Immunizations**<br><br>Covered Medicare Part B services include:<br>• Pneumonia vaccines<br>• Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary<br>• Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B<br>• COVID-19 vaccines<br>• Other vaccines if you're at risk and they meet Medicare Part B coverage rules<br><br>We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information. | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the |

| Covered Service | What you pay |
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| | preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>$175 deductible applies, then 50% coinsurance in a Primary Care Physician's office.<br><br>$175 deductible applies, then 50% coinsurance in a Specialty Physician's office.<br><br>**In-Network:**<br><br>20% coinsurance for other vaccines.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance for other vaccines. |
| **Inpatient hospital care**<br><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.<br><br>Covered services include but aren't limited to:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals including special diets<br>• Regular nursing services<br>• Costs of special care units (such as intensive care or coronary care units)<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Necessary surgical and medical supplies<br>• Use of appliances, such as wheelchairs | **(Requires provider preauthorization in-network except for emergency admissions.)**<br><br>**In-Network:**<br><br>Tier A facility:<br><br>$375 copayment per day, days 1 through 6, per benefit period.<br><br>$0 copayment per day, days 7 and beyond. Unlimited days for Medicare covered stays.<br><br>$2,250 annual copayment maximum.<br><br>Tier B facility:<br><br>$550 copayment per day, days 1 through 4 per benefit period.<br><br>$0 copayment per day, days 5 and beyond. Unlimited days for Medicare covered stays.<br><br>$2,445 annual copayment maximum.<br><br>Amounts you pay for Inpatient Hospital care at either Tier A or Tier B facilities count toward both maximums. However, the plan |

| Covered Service | What you pay |
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| • Operating and recovery room costs<br>• Physical, occupational, and speech language therapy<br>• Inpatient substance abuse services<br>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant 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 Passport Connect (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All | begins covering your Inpatient Hospital care in full **only once you've reached the out-of-pocket maximum for the tier where the service is received**. For example, if you receive care at a Tier B facility, you must reach the **$2,445** maximum (even if you've already paid **$2,250** at a Tier A facility).<br><br>Copayment applies on the date of admission but not on the date of discharge.<br><br>Copayment is not waived when member is discharged from acute hospital and admitted to SNF. This includes SNF to SNF.<br><br>A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital or skilled nursing facility care for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.<br><br>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.<br><br>You are responsible for the maximum number of per day cost shares for each benefit period. If you are discharged from the hospital prior to using the maximum number of per day cost shares, and you are readmitted during the benefit period, you will be responsible for the remaining number of per day cost shares. You will not be responsible for more than the maximum |

| Covered Service | What you pay |
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| other components of blood are covered starting with the first pint.<br>• Physician services<br><br>**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.<br><br>Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. | number of per day cost shares per benefit period.<br><br>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.<br><br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance<br><br>Copayment is not waived when member is discharged from acute hospital and admitted to SNF. This includes SNF to SNF. |
| **Inpatient services in a psychiatric hospital**<br><br>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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.<br><br>If you get your mental health care at an in-network acute facility, Independent Health will follow inpatient hospital cost share (see above). | **(Requires provider preauthorization except for emergency admissions in-network.)**<br><br>**In-Network:**<br><br>$395 copayment per day, days 1 through 4 of each benefit period, then<br><br>$0 copayment per day, days 5 through 90 of each benefit period.<br><br>Cost sharing is charged for each inpatient stay.<br><br>A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital or skilled nursing facility care for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. You are |

| Covered Service | What you pay |
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| | responsible for the maximum number of per day cost shares for each benefit period. If you are discharged from the hospital prior to using the maximum number of per day cost shares, and you are readmitted during the benefit period, you will be responsible for the remaining number of per day cost shares. You will not be responsible for more than the maximum number of per day cost shares per benefit period.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance.<br>Copayment is not waived when member is discharged from acute hospital and admitted to SNF. This includes SNF to SNF. |
| **Inpatient vs. Outpatient Level of Care** i.e. **Observation Bed**<br>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.<br>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 | |

| Covered Service | What you pay |
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| remain in the hospital but the co-payment applied will be for outpatient services as defined in Chapter 4, Section 2.1. Collaborative discussion will occur between the medical staff at the hospital and the medical staff at Independent Health to determine the level of care most appropriate for your medical needs.<br><br>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.<br><br>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.<br><br>Custodial care is excluded from Medicare coverage. Custodial care serves to assist | |

| Covered Service | What you pay |
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| an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is 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.<br><br>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 through the QIO. See Chapter 9, Section 7 for instructions on how to do that. If it is deemed your discharge is appropriate, and you choose to remain at the hospital, the facility has the right to bill you in full for any charges incurred. | |
| **Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay**<br><br>If the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility | **(Certain services may require provider preauthorization in-network.)**<br>You are responsible for 100% of the costs after 100 days as a SNF inpatient per benefit period. |

| Covered Service | What you pay |
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| (SNF). Covered services include, but aren't limited to: | |
| • Physician services | **In-Network:**<br>Tier A Hospitalist: $0 copayment for physician services by a Hospitalist.<br>Tier B Hospitalist: $20 copayment for physician services by a Hospitalist.<br>$55 copayment for physician services by a Specialty Physician.<br>**Out-of-Network:**<br>$175 deductible applies, then:<br>50% coinsurance for physician services by a Primary Care Physician.<br>50% coinsurance for physician services by a Specialty Physician.**<br>**For other services performed in conjunction with the visit, please see specific service for cost share. |
| • Lab tests (inpatient) | **In-Network:**<br>$0 copayment for lab tests<br>20% coinsurance for molecular and predisposed genetic testing.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for lab tests |
| • Diagnostic tests, such as:<br>  • Electromyogram (EMG)<br>  • Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests) | **In-Network:**<br>Tier A PCP: $0 copayment for each Medicare-covered diagnostic test from a Primary Care Physician. |

| Covered Service | What you pay |
|---|---|
| • Echocardiograms<br>• EKG | Tier B PCP: $20 copayment for each Medicare-covered diagnostic test from a Primary Care Physician.<br>$55 copayment for each Medicare-covered diagnostic test from a Specialty Physician.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered diagnostic test |
| • X-ray | **In-Network:**<br>$45 copayment for each Medicare-covered x-ray**<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered x-ray.<br>**Both copayments will apply if both a diagnostic x-ray and an advanced radiology service are billed on the same day by the same provider. |
| • Advanced Radiology Diagnostic Service (like CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET scans) | **In-Network:**<br>Tier A provider: $225 copayment for each Medicare-covered advanced radiology service**<br>Tier B provider: $550 copayment for each Medicare-covered advanced radiology service**<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered advanced radiology service<br>**Both copayments will apply if both a diagnostic x-ray and an advanced radiology |

| Covered Service | What you pay |
|---|---|
| | service are billed on the same day by the same provider. |
| • Radiation Therapy (Medicare covered therapeutic radiological services), radium, and isotope therapy including technician materials and services | **In-Network:**<br>20% coinsurance for Medicare-covered radiation therapy.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered radiation therapy. |
| • Surgical dressings | **In-Network:**<br>$0 copayment for each Medicare-covered surgical dressing item.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered surgical dressing item. |
| • Splints, casts, and other devices used to reduce fractures and dislocations | **In-Network:**<br>$0 copayment for each Medicare-covered item to treat fractures and dislocations.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance 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 | **In-Network:**<br>$0 copayment for each Medicare-covered internal prosthetic or orthotic.<br>20% coinsurance for external Medicare-covered prosthetics. |

| Covered Service | What you pay |
|---|---|
| • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition | **Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered prosthetic or orthotic<br>**In-Network:**<br>20% coinsurance for Medicare-covered 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.<br>20% coinsurance for Medicare-covered ostomy supplies.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered 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<br>$175 deductible applies, then 50% for Medicare-covered ostomy supplies. |
| • Physical therapy, speech therapy, and occupational therapy | **In-Network:**<br>$30 copayment for each Medicare-covered physical therapy, speech therapy, and occupational therapy treatment or evaluation.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance per Medicare-covered physical therapy, speech therapy, and occupational therapy treatment or evaluation. |
| **Medical nutrition therapy** | **In-Network:** |

| Covered Service | What you pay |
|---|---|
| This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.<br><br>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's<br><br>A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance for Medicare-covered medical nutrition therapy services.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>$175 Deductible applies, then:<br><br>50% coinsurance in a Primary Care Physician's office.<br><br>50% coinsurance in a Specialty Physician's office. |
| **Medicare Diabetes Prevention Program (MDPP)** | The MDPP is a 2-year program and has a once per lifetime limit.<br><br>**In-Network:** |

| Covered Service | What you pay |
|---|---|
| **MDPP services are covered for eligible people under all Medicare health plans.**.<br><br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. | There is no coinsurance, copayment, or deductible for the MDPP benefit.<br><br>**Out-of-Network:**<br><br>50% coinsurance for the MDPP program. |
| **Medicare Part B drugs**<br><br>**These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:**<br>• Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services<br>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)<br>• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan<br>• The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy | **(Certain services may require provider preauthorization.)**<br><br>**In-Network:**<br><br>0% minimum coinsurance for each Medicare-covered Part B drug and/or biologic.<br>20% maximum coinsurance for each Medicare-covered Part B drug and/or biologic.<br>Part B drugs may be subject to step therapy.<br>Part B insulin is subject to a coinsurance cap of $35 for one-month's supply of insulin.<br>If a Part B drug is administered in the office or outpatient hospital setting, or home, subject to 0% - 20% coinsurance in addition to the office/outpatient hospital or home health agency member liability for the drug administration.<br>However, if you are treated or monitored for a new or an existing medical condition during the Part B infusion or injection, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office. |

| Covered Service | What you pay |
|---|---|
| if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them<br>• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug<br>• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision<br>• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does.<br>• Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug | Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance in a Primary Care Physician's office.<br>$175 deductible applies, then 50% coinsurance in a Specialty Physician's office. |

| Covered Service | What you pay |
|---|---|
| • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B<br>• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics<br>• Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta)<br>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>• Parenteral and enteral nutrition (intravenous and tube feeding)<br>This 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."<br>We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit.<br>Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for | |

| Covered Service | What you pay |
|---|---|
| Part D drugs through our plan is explained in Chapter 6. | |
| **Obesity screening and therapy to promote sustained weight loss**<br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.<br>**Out-of-Network:**<br>50% coinsurance for preventive obesity screening and therapy. |
| **Opioid treatment program services**<br>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.<br>• Dispensing and administration of MAT medications (if applicable)<br>• Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br>• Intake activities<br>• Periodic assessments | **In-Network**<br>$40 copayment per Medicare-covered Opioid Treatment Program session.<br>If a drug is administered in the office: up to 20% coinsurance in addition to the office visit copay for the administration of the drug.<br>If a drug is administered in a pharmacy: see your drug list for the appropriate tier pricing.<br>**Out-of-Network**<br>$175 deductible applies, then 50% coinsurance per treatment session.<br>If a drug is administered in the office: $175 deductible applies, then 50% coinsurance in addition to the office visit copay for the administration of the drug.<br>If a drug is administered in a pharmacy: see your drug list for appropriate tier pricing. |

| Covered Service | What you pay |
|---|---|
| **Outpatient diagnostic tests and therapeutic services and supplies**<br>Covered services include, but aren't limited to:<br>• X-rays | **((Provider preauthorization may apply for some services in-network.)**<br>**In-Network:**<br>$45 copayment for each Medicare-covered x-ray**<br>(If x-ray services are performed in the provider's office during an office visit, the appropriate office visit copayment and x-ray copayment will apply)<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered x-ray |
| • Advanced Radiology Diagnostic Service (like CT scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging, and PET scans) | **In-Network:**<br>Tier A provider: $225 copayment for each Medicare-covered advanced radiology service**<br>Tier B provider: $550 copayment for each Medicare-covered advanced radiology service**<br>(If Advanced Radiology Services are performed in the provider's office during an office visit, the appropriate office visit copayment and Advanced Radiology Service copayment will apply)<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered advanced radiology service.<br>**Two copayments will apply if both a diagnostic x-ray and an advanced radiology |

| Covered Service | What you pay |
|---|---|
| | service are billed on the same day by the same provider. |
| • Radiation (radium and isotope) therapy including technician materials and supplies | **In-Network:**<br>20% coinsurance for each Medicare-covered radiation therapy service.<br>(If outpatient radiation therapy services are performed in the provider's office during an office visit, the appropriate office visit copayment and outpatient radiation therapy copayment will apply.)<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance each Medicare-covered radiation therapy service. |
| • Surgical supplies, such as dressings | **In-Network:**<br>$0 copayment for each Medicare-covered surgical supply item.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered surgical supply item. |
| • Splints, casts, and other devices used to reduce fractures and dislocations | **In-Network:**<br>$0 copayment for each Medicare-covered item used to treat fractures and dislocations.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered item used to treat fractures and dislocations. |
| • Laboratory tests | **In-Network:**<br>$0 copayment for Medicare-covered lab test |

| Covered Service | What you pay |
|---|---|
| • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.<br>• Other outpatient diagnostic tests | 20% coinsurance for molecular and predisposed genetic testing.<br><br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered lab test<br><br>**In-Network:**<br>$0 copayment for blood<br>Transfusion requires outpatient hospital copayment or office visit copayment.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for blood.<br><br>**In-Network:**<br>Tier A Primary Care Physician: $0 copayment for other Medicare-covered outpatient diagnostic tests.<br>Tier B Primary Care Physician: $20 copayment for other Medicare-covered outpatient diagnostic tests.<br>$55 copayment for Specialty Physician for other Medicare-covered outpatient diagnostic tests.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for other Medicare-covered outpatient diagnostic tests. |
| **Outpatient hospital observation**<br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. | **In-Network:**<br>Tier A facility: $375 copayment per visit for Medicare-covered outpatient hospital observation services |

| Covered Service | What you pay |
|---|---|
| For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br><br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.<br><br>Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available 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. | Tier B facility: $550 copayment per visit for Medicare-covered outpatient hospital observation services<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance |
| **Outpatient hospital services**<br><br>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br><br>Covered services include, but aren't limited to:<br><br>• Observation services<br>• Services in an outpatient clinic | **(Provider preauthorization may apply for some services in-network, except for services in an emergency department.)**<br><br>**In-Network:**<br><br>Tier A facility: $375 copayment per visit for Medicare-covered outpatient hospital observation services<br><br>Tier B facility: $550 copayment per visit for Medicare-covered outpatient hospital observation services |

| Covered Service | What you pay |
|---|---|
| • Same day outpatient surgery (includes diagnostic “scopes” such as an endoscopy) | **Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance<br>**In-Network:**<br>Tier A PCP: $0 copayment for Primary Care Physician in an outpatient clinic.<br>Tier B PCP: $20 copayment for Primary Care Physician in an outpatient clinic.<br>$55 copayment for Specialty Physician in an outpatient clinic.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance**<br>**For other services performed in conjunction with the office visit, please see specific service for cost share.<br>**In-Network:**<br>$375 copayment in a freestanding ambulatory surgery center for Medicare-covered same day outpatient surgical procedures,<br>$175 deductible applies for Outpatient Hospital, then:<br>Tier A facility: $425 copayment in an outpatient hospital for Medicare-covered same day outpatient surgical procedures.<br>Tier B facility: $550 copayment in an outpatient hospital for Medicare-covered same day outpatient surgical procedures. |

| Covered Service | What you pay |
|---|---|
| | **Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered same day outpatient surgical procedures.<br><br>To determine if the location is a freestanding ambulatory surgery center or an outpatient hospital facility, see the Physician/Provider Directory. |
| • Laboratory and diagnostic tests billed by the hospital | **In-Network:**<br>$0 copayment or 20% coinsurance for Medicare-covered lab tests.<br><br>Higher cost share is for molecular and predisposed genetic testing.<br><br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered lab tests. |
| • Diagnostic tests billed by the hospital, such as:<br>  • Electromyogram (EMG)<br>  • Cardiovascular Stress Tests (See Advanced Radiology for Nuclear Stress Tests)<br>  • Echocardiograms<br>  • EKG | **In-Network:**<br>Tier A Primary Care Physician: $0 copayment for Medicare-covered outpatient diagnostic tests billed by the hospital,<br><br>Tier B Primary Care Physician: $20 copayment for Medicare-covered outpatient diagnostic tests billed by the hospital,<br><br>$55 copayment for Specialty Physician for Medicare-covered outpatient diagnostic tests billed by the hospital.<br><br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered outpatient diagnostic tests billed by the hospital. |

| Covered Service | What you pay |
|---|---|
| • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it. | **In-Network:**<br>$35 copayment per Medicare-covered outpatient mental health visit.<br>$55 copayment for each partial hospitalization visit<br>**Out-of-Network:**<br>$175 deductible applies, then:<br>50% coinsurance per Medicare-covered outpatient mental health visit or partial hospitalization. |
| • X-rays and other radiology services billed by the hospital | **In-Network:**<br>$45 copayment for each Medicare-covered x-ray service.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered x-ray service. |
| • Advanced Radiology Services (Like CT Scan, MRI/MRA, Myocardial Nuclear Perfusion Imaging and PET Scans.) | **In-Network:**<br>Tier A provider: $225 copayment for each Medicare-covered advanced radiology service.**<br>Tier B provider: $550 copayment for each Medicare-covered advanced radiology service.**<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered advanced radiology service.<br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |

| Covered Service | What you pay |
|---|---|
| • Radiation (radium and isotope) therapy including technician materials and supplies | **In-Network:**<br>20% coinsurance for each Medicare-covered radiation therapy service.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered radiation therapy service. |
| • Medical supplies such as splints and casts | **In-Network:**<br>$0 copayment for Medicare-covered medical supplies<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered medical supplies |
| • Certain screenings and preventive services | **In-Network:**<br>$0 copayment for each preventive screening or service if listed as a preventive screening<br>**Out-of-Network:**<br>50% coinsurance for each preventive screening or service if listed as a preventive screening. |
| • Certain drugs and biologicals you can't give yourself<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't | **In-Network:**<br>0%-20% coinsurance for each Medicare-covered Part B drugs and biologics.<br>If a Part B drug is administered in the office or outpatient hospital setting, or home, subject to 0%-20% in addition to the |

| Covered Service | What you pay |
|---|---|
| sure if you're an outpatient, ask the hospital staff. | office/outpatient member liability for the administration of the drug.<br>**Out-of-Network:**<br>$175 deductible applies, then:<br>50% coinsurance for Part B drugs and biologics.<br>If a Part B drug is administered in the office or outpatient hospital setting, or home, subject to 50% coinsurance in addition to the office/outpatient member liability for administration of the drug. |
| **Outpatient mental health care**<br>Covered services include:<br>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. | **In-Network:**<br>$35 copayment per Medicare-covered visit<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance |
| **Outpatient rehabilitation services**<br>Covered services include physical therapy, occupational therapy, and speech language therapy.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | **(Provider preauthorization required after initial evaluation)**<br>**In-Network:**<br>$30 copayment per service. You are responsible for one copayment for each therapy treatment or evaluation.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance |
| **Outpatient substance use disorder services** | **In-Network:** |

| Covered Service | What you pay |
|---|---|
| Outpatient medical treatment for alcohol abuse, chemical abuse and chemical dependency. | $40 copayment for each Medicare-covered service.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for each Medicare-covered service. |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br>**Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. | **(Certain procedures may require provider preauthorization in-network.)**<br>**In-Network:**<br>$375 copayment in a freestanding ambulatory surgery center.<br>$175 deductible applies, then<br>Tier A facility: $425 copayment in an outpatient hospital facility.<br>Tier B facility: $550 copayment in an outpatient hospital facility.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance<br>To determine of the location is a freestanding ambulatory surgical center or an outpatient hospital facility, see the Physician/Provider Directory. The most up-to-date Physician/Provider Directory is on our website under the "Find A Doctor" search tool at www.independenthealth.com/IndividualsFamilies/FindADoctor. |
| **Partial hospitalization services and Intensive outpatient services**<br>*Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center | **(Requires provider preauthorization in-network)**<br>**In-Network:**<br>$55 copayment per visit for Medicare-covered services. |

| Covered Service | What you pay |
|---|---|
| that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.<br>*Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. | **Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance |
| **Physician/Practitioner services, including doctor's office visits**<br>Covered services include:<br>• Medically necessary medical care or surgery services you get in a physician's office | **In-Network:**<br>Tier A PCP: $0 copayment for Medicare-covered medical care or surgery services in a physician's office.<br>Tier B PCP: $20 copayment for Medicare-covered medical care or surgery services in a physician's office.<br>$55 copayment for Medicare-covered medical care or surgery services in a physician's office.<br>**Out-of-Network:**<br>$175 deductible applies, then<br>50% coinsurance** for Primary Care Physician for Medicare-covered medical care or surgery services in a physician's office. |

| Covered Service | What you pay |
|---|---|
| | 50% coinsurance** for Specialty Physician for Medicare-covered medical care or surgery services in a physician's office.<br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| • Medically-necessary medical care or surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location | **In-Network:**<br>Freestanding Ambulatory Surgery Center: $375 facility copayment.<br>$175 deductible applies, then<br>Tier A Outpatient Hospital Facility: $425 facility copayment.<br>Tier B Outpatient Hospital Facility: $550 facility copayment.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance in a freestanding ambulatory surgery center or outpatient hospital facility.<br>To determine of the location is a freestanding ambulatory surgical center or an outpatient hospital facility, see the Physician/Provider Directory. |
| • Consultation, diagnosis, and treatment by a specialist | **In-Network:**<br>$55 copayment for a consultation with a Specialty Physician **<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for a consultation with a Specialty Physician **<br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |

| Covered Service | What you pay |
|---|---|
| • Basic hearing and balance exams performed by your PCP OR specialist, if your doctor orders it to see if you need medical treatment | **In-Network:**<br>Tier A PCP: $0 copayment for Primary Care Physician for basic hearing and balance exams.<br>Tier B PCP: $20 copayment for Primary Care Physician for basic hearing and balance exams.<br>$55 copayment for Specialty Physician for basic hearing and balance exams.<br>**Out-of-Network:**<br>$175 deductible applies, then<br>50% coinsurance for Primary Care Physician for basic hearing and balance exams.<br>50% coinsurance for Specialty Physician for basic hearing and balance exams. |
| • **Telehealth** – Additional Telehealth Services<br>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 via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. Contact your Provider(s) to see if they participate in telehealth services. | **In-Network:**<br>Cost share based on place of service.<br>Tier A PCP: $0 copayment for Primary Care Physician for additional telehealth services.<br>Tier B PCP: $20 copayment for Primary Care Physician for additional telehealth services.<br>$55 copayment for Specialty Physician for additional telehealth services<br>$35 copayment for telehealth services with a mental health provider.<br>$30 copayment for telehealth services with a physical therapist, speech therapist, or occupational therapist.<br>$40 copayment for a telehealth visit for urgent care.<br>**Out-of-Network:**<br>$175 deductible applies, then |

| Covered Service | What you pay |
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| | Cost share based on place of service.<br>50% coinsurance for Primary Care Physician for additional telehealth services.<br>50% coinsurance for Specialty Physician for additional telehealth services.<br>50% coinsurance for telehealth services by a mental health provider.<br>50% coinsurance for telehealth services by a physical therapist, speech therapist, or occupational therapist.<br>$40 copayment for telehealth services with an urgent care provider. |
| • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other places approved by Medicare. | **In-Network**<br>Tier A PCP: $0 copayment for certain telehealth services from a Primary Physician in a rural area.<br>Tier B PCP: $20 copayment for certain telehealth services from a Primary Physician in a rural area.<br>$55 copayment for certain telehealth services from a Specialty Physician in a rural area.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Specialty Physician for certain telehealth services.in rural areas. |
| • 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 | |

| Covered Service | What you pay |
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| • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>  • You have an in-person visit within 6 months prior to your first telehealth visit<br>  • You have an in-person visit every 12 months while getting these telehealth services<br>  • Exceptions can be made to the above for certain circumstances<br>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:**<br>  • You're not a new patient **and**<br>  • The check-in isn't related to an office visit in the past 7 days **and**<br>  • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:**<br>  • You're not a new patient **and** | |

| Covered Service | What you pay |
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| • The evaluation isn't related to an office visit in the past 7 days **and**<br>• The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Consultation your doctor has with other doctors by phone, internet, or electronic health record | |
| • Second opinion by another network provider prior to surgery | **In-Network**<br>$55 copayment** for Specialty Physician for a second opinion.<br>**Out-of-Network**<br>$175 deductible applies, then 50% coinsurance for second opinions**<br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| • **Non-routine dental care** (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).<br>• Accidental injury to sound and natural teeth is not covered.<br><br>Examples of non-covered services include:<br>• The cost to repair or replace teeth (natural or dentures)<br>• The cost to prepare the jaw for dentures, even if dentures are required | **(Non-routine dental care requires provider preauthorization after initial visit.)**<br>**In-Network:**<br>Tier A PCP: $0 copayment if emergent dental care provided in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment if emergent dental care provided in a Primary Care Physician's office.<br>$55 copayment if emergent dental care provided in a Specialty Physician's office.<br>$115 facility copayment if emergent dental care provided in an emergency room setting.<br>$375 copayment if emergent dental care is provided in an outpatient freestanding ambulatory surgery center facility, |

| Covered Service | What you pay |
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| because of a covered loss such as tumor removal or accidental trauma.<br><br>(This is **NOT** preventive/routine dental) | $175 deductible applies, then<br>Tier A Outpatient Hospital Facility: $425 copayment if emergent dental care is provided in an outpatient hospital.<br>Tier B Outpatient Hospital Facility: $550 copayment if emergent dental care is provided in an outpatient hospital.<br>To determine if the location is a freestanding ambulatory surgery center or an outpatient hospital facility, see the Physician/Provider Directory.<br>**Out-of-Network:**<br>$175 deductible applies, then<br>50% coinsurance if emergent dental care is provided in a Primary Care Physician's office.<br>50% coinsurance if emergent dental care is provided in a Specialty Physician's office.<br>$115 facility copayment if emergent dental care provided in an emergency room setting.<br>50% coinsurance if emergent dental care is provided in an outpatient free-standing ambulatory surgery center facility or outpatient hospital. |
| • Home Physician visits | **In-Network:**<br>Tier A PCP: $0 copayment** for home visit by a Primary Care physician.<br>Tier B PCP: $20 copayment** for home visit by a Primary Care physician.<br>$55 copayment** for home visit by a Specialty Physician.<br>**Out-of-Network:** |

| Covered Service | What you pay |
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| | $175 deductible applies, then<br>50% coinsurance** for home visit by a Primary Care Physician.<br>50% coinsurance** for home visit by a Specialty Physician.<br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| • Telemedicine - Teladoc®<br>In addition to telehealth services, our plan offers extended telemedicine benefits through Teladoc®. Benefit limited to Teladoc® Providers. Teladoc® provides telephone and online internet consultations between members and Teladoc® Providers for medical conditions that are not an Emergency Condition. Independent Health's telemedicine service provides coverage within the United States and anywhere world-wide where there is internet service. Independent Health's telemedicine benefit should not be used if a member is experiencing a medical emergency. The service is intended to provide a solution for non-emergency medical situations.<br>The service is not intended to replace the primary care physician/patient relationship but rather offer members an alternative option to an urgent care facility or when a member is unable to obtain services from their primary care physician for many common medical issues including but not limited to:<br>• Cold and Flu Symptoms<br>• Bronchitis | **In-Network:**<br>$0 copayment with a Teladoc® provider for behavioral health services.<br>$25 copayment with a Teladoc® provider for other services.<br>The service is available 24 hours a day, 7 days a week and may be accessed if traveling throughout the United States or worldwide anywhere there is internet access.<br>**Out-of-Network:**<br>Telemedicine services rendered through a provider other than a Teladoc® provider are not covered. |

| Covered Service | What you pay |
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| • Allergies<br>• Poison Ivy<br>• Eye Infection/Pink Eye<br>• Respiratory Infection<br>• Strep Throat<br>• Sinus Problems<br>• Behavioral Health<br>**Consultation Access:**<br>There are three ways to register or set up a consultation:<br>1. Visit the Teladoc website at www.teladoc.com/mobile, and provide the required information along with your medical history.<br>2. Download the mobile app at Teladoc.com/mobile.<br>3. Call Teladoc at 1-800-Teladoc (1-800-835-2362) to create an account. TTY users call 1-800-877-8973.<br>Telephone service is only available within the United States.<br>We also offer Teladoc via a smart phone or tablet app anywhere in the world where there is internet access. Download the app from www.teladoc.com/ih to your smart phone or tablet, create your account and you'll have access to a doctor from your home state from most places in the world, including on cruise ships, within 60 minutes. If you have already created your account, you can access Global Care through it. If it is appropriate for your health condition, a prescription recommendation will be sent to you that you can take to a pharmacy. There is a CMS regulation that prohibits Independent Health or Medicare from covering the cost | |

| Covered Service | What you pay |
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| of any Part D. prescription drug when it's purchased outside of the United States or it's territories.<br><br>Account creation involves completing baseline health information such as providing a medical history, allergy information, list of medications, health problems, family history and Primary Care Physician contact information.<br><br>If necessary, the doctor may prescribe medication for your diagnosis. Prescriptions for short-term antibiotics, antihistamines or anti-bacterial agents can be sent to your preferred pharmacy. Nearly all of the drugs prescribed are generic. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Prescriptions filled outside of the United States are not covered. | |
| **Podiatry services**<br><br>Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs. Limit once every 60 days. | **In-Network:**<br><br>$55 copayment** in a Specialty Physician's office.<br><br>$375 facility copayment in a freestanding ambulatory surgery center;<br>$175 deductible applies, then<br><br>Tier A facility: $425 facility copayment in an outpatient hospital facility.<br><br>Tier B facility: $550 facility copayment in an outpatient hospital facility.<br><br>To determine if the location is a freestanding ambulatory surgery center or |

| Covered Service | What you pay |
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| | an outpatient hospital facility, see the Physician/Provider Directory.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then<br><br>50% coinsurance in a physician's office**<br><br>50% coinsurance in an ambulatory surgery center or outpatient hospital setting.<br><br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| **Prostate cancer screening exams**<br><br>For men aged 50 and older, covered services include the following once every 12 months:<br><br>Prostate Specific Antigen (PSA) test | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for an annual PSA test.<br><br>Separate office visit cost sharing will apply if prostate screening is performed separate from the "Annual Wellness Visit" exam:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>Limit one preventive screening per year.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>$175 deductible applies, then |

| Covered Service | What you pay |
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| | Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance** in a Primary Care Physician's office<br><br>50% coinsurance in a Specialty Physician's office**<br><br>PSA test: 50% coinsurance<br><br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| **Prosthetic and orthotic devices and related supplies**<br><br>Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. | **(Certain items may require provider preauthorization.)**<br><br>**In-Network:**<br><br>20% coinsurance for each Medicare-covered standard prosthetic device.<br><br>$0 copayment for related supplies.<br><br>20% coinsurance for enteral and parenteral nutrition.<br><br>20% coinsurance for Medicare-covered ostomy supplies.<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance |
| **Pulmonary rehabilitation services** | Limited to 36 visits per occurrence |

| Covered Service | What you pay |
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| Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | **In-Network:**<br>$0 copayment for Medicare-covered pulmonary rehabilitation services.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance |
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.<br>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>50% coinsurance<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>$175 deductible applies, then: |

| Covered Service | What you pay |
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| | 50% coinsurance in a Primary Care Physician's office.<br>50% coinsurance in a Specialty Physician's office. |
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>For qualified people, a LDCT is covered every 12 months.<br>**Eligible members are**: people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.<br>*For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.<br>**Out-of-Network:**<br>LDCT 50% coinsurance |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |

| Covered Service | What you pay |
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| 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.<br><br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office.<br><br>**Out-of-Network:**<br><br>50% coinsurance in a Primary Care Physician's office**<br><br>50% coinsurance in a Specialty Physician's office**<br><br>**For other services performed in conjunction with the office visit, please see specific service for cost share.<br><br>**Out-of-Network Lab Work:**<br><br>50% coinsurance<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>$175 deductible applies, then:<br><br>50% coinsurance in a Primary Care Physician's office.<br><br>50% coinsurance in a Specialty Physician's office. |

| Covered Service | What you pay |
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| **Services to treat kidney disease**<br>Covered services include:<br>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime | **In-Network:**<br>$0 copayment for kidney disease education services.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br>$55 copayment in a Specialty Physician's office.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for kidney disease education services<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the service, $175 deductible applies, then an office visit copayment will apply for the care received for the new or existing medical condition:<br>$175 deductible applies, then:<br>50% coinsurance in a Primary Care Physician's office.<br>50% coinsurance in a Specialty Physician's office. |

| Covered Service | What you pay |
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| • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) | **In-Network:**<br>20% coinsurance per outpatient dialysis treatment<br>**Out-of-Network:**<br>$175 deductible applies, then 20% coinsurance per outpatient dialysis treatment |
| • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) | **For inpatient dialysis treatments, see Inpatient Hospital Care cost share.** |
| • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) | **In-Network:**<br>$0 copayment for Medicare-covered services for self-dialysis training.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for Medicare-covered services for self-dialysis training |
| • Home dialysis equipment and supplies | **In-Network:**<br>20% coinsurance for home dialysis equipment<br>$0 copayment for home dialysis supplies.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% 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)<br>Certain drugs for dialysis are covered under Medicare Part B. For information | **In-Network:**<br>$0 copayment for home support services.<br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for home support services. |

| Covered Service | What you pay |
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| about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. | See Medicare Part B Drugs for Part B dialysis drugs. |
| **Skilled nursing facility (SNF) care**<br><br>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)<br><br>Covered up to 100 days per benefit period for skilled services only (includes subacute admissions in a skilled nursing facility.)<br><br>No prior hospital stay is required.<br><br>Covered services include but aren't limited to:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy and speech therapy<br>• Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs | **(Requires provider preauthorization.)**<br><br>**In-Network:**<br><br>$0 copayment per day for days through 20.<br><br>$218 copayment per day for days 21 through 100.<br><br>No coverage days 101+.<br><br>Covered up to 100 days per benefit period. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital or skilled care in a SNF for 60 days in a row. If you go into a hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.<br><br>Copayment is not waived when member is discharged from acute hospital and admitted to a SNF. This includes SNF to SNF.<br><br>You are responsible for the maximum number of per day cost shares for each benefit period. If you are discharged from the skilled nursing facility prior to using the maximum number of per day cost shares, and you are readmitted during a benefit period, you will be responsible for the remaining number of per day cost shares.<br><br>You will not be responsible for more than the maximum number of per day cost shares per benefit period.<br><br>**Out-of-Network:**<br>$175 deductible applies, then 50% coinsurance for days 1 through 100. |

| Covered Service | What you pay |
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| • X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br><br>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.<br>• 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)<br>• A SNF where your spouse or domestic partner is living at the time you leave the hospital | Copayment is not waived when member is discharged from acute hospital and admitted to SNF. This includes SNF to SNF. |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br><br>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: | **In-Network:**<br><br>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br><br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br><br>Tier A PCP: $0 copayment in a Primary Care Physician's office.<br><br>Tier B PCP: $20 copayment in a Primary Care Physician's office.<br><br>$55 copayment in a Specialty Physician's office. |

| Covered Service | What you pay |
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| • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease<br>• Are competent and alert during counseling<br>• A qualified physician or other Medicare-recognized practitioner provides counseling<br><br>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) | **Out-of-Network:**<br><br>50% coinsurance** in a Primary Care Physician's office.<br><br>50% coinsurance** in a Specialty Physician's office if you do not have signs or symptoms of tobacco-related disease.<br><br>**For other services performed in conjunction with the office visit, please see specific service for cost share. |
| **Supervised Exercise Therapy (SET)**<br><br>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.<br><br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br><br>The SET program must:<br>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication | **In-Network:**<br><br>$20 copayment per Medicare-covered Supervised Exercise Therapy<br><br>**Out-of-Network:**<br><br>$175 deductible applies, then 50% coinsurance |

| Covered Service | What you pay |
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| • Be conducted in a hospital outpatient setting or a physician's office<br>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD<br>• 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<br><br>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. | |
| **Urgently needed services**<br><br>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. | **In-Network:**<br><br>$40 copayment per visit in an urgent care center or walk in clinic.<br><br>**Out-of-Network:**<br><br>$40 copayment per visit in an urgent care center or walk in clinic.<br><br>**Outside United States and its territories:**<br><br>Worldwide coverage: Deductible does not apply. Maximum plan benefit limit of $10,000. The $10,000 plan limit is per occurrence for the combined unforeseen event outside of the USA. Coverage ends when $10,000 limit is reached. See Ambulance, Urgent Care and Emergency Care for appropriate cost share |

| Covered Service | What you pay |
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| **Vision care**<br>Covered services include:<br>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.<br>• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older.<br>• For people with diabetes, screening for diabetic retinopathy is covered once per year.<br>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. | **In-Network:**<br>Medicare-covered medical eye exam: $55 copayment<br>$0 copayment for glaucoma screening as part of a routine eye exam from an EyeMed provider.<br>$0 copayment for diabetic retinopathy screening. Retinal imaging to diagnose other injury or disease of the eye will have an office copay as outlined below.<br>However, if you are treated or monitored for a new or an existing medical condition during the visit when you receive the preventive service, an office visit copayment will apply for the care received for the new or existing medical condition:<br>Tier A PCP: $0 copayment in a Primary Care Physician's office<br>Tier B PCP: $20 copayment in a Primary Care Physician's office<br>$55 copayment in a Specialty Physician's office<br>Like Original Medicare, only standard frames and lenses from an EyeMed Provider are covered in full after each Post Cataract surgery.<br>$0 copayment for one pair of conventional contact lenses. Conventional contact lenses (in lieu of frames and lenses) include fit, follow-up and materials from an EyeMed provider. |

| Covered Service | What you pay |
|---|---|
| | The member will be responsible for $0 copayment for standard, non-vision correcting lenses during cataract surgery. The member will be responsible for any additional costs for lenses and related services which correct your vision and replace your need to wear glasses.<br><br>Frequency: Once per eye per surgery.<br><br>Screening for diabetic retinopathy is covered as part of your medical eye exam.<br><br>**Out-of-Network:**<br><br>Medicare-covered Medical Eye Exam: $175 deductible applies, then 50% coinsurance<br><br>Glaucoma screening is subject to 50% coinsurance<br><br>Screening for diabetic retinopathy is covered as part of your medical eye exam. Exam copay will apply. |
| **Supplemental Vision**<br><br>• **Routine vision exam**<br><br>Routine Eye Exam with dilation from an EyeMed Provider (one exam every 12 months). Glaucoma screening every 12 months (for high-risk individuals, individuals with family history of glaucoma, individuals with diabetes and African Americans who are age 50 and older). | **In-Network:**<br><br>$0 copayment for routine vision exam from an EyeMed Provider. Limit: One routine eye exam every year from and EyeMed provider. Member cannot combine any promotional offers with our vision benefit.<br>**Out-of-Network:**<br><br>$65 copayment for routine vision exam. Limit: One routine eye exam every year. |

| Covered Service | What you pay |
|---|---|
| • **Routine Eye Wear**<br>(Such as glasses (lenses and frames) or contact lenses) | **In-Network and Out-of-Network combined:**<br>$200 coverage limit for routine eyewear every year from an EyeMed Provider.<br>Member cannot combine any promotional offers with our vision benefit. |
| **Welcome to Medicare preventive visit**<br>Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed.<br>**Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit. | **In-Network:**<br>There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.<br>**Out-of-Network:**<br>50% coinsurance** in a Primary Care Physician's office.<br>50% coinsurance** in a Specialty Physician's office.<br>****For other services performed in conjunction with the office visit, please see specific service for cost share.** |

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

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

| *Code* | *Description* |
|---|---|
| E0981 | Wheelchair accessory, seat upholstery, replacement only, each |
| E0982 | Wheelchair accessory, back upholstery, replacement only, each |
| E0986 | Manual wheelchair accessory, push-rim activated power assist system |
| E0990 | Wheelchair accessory, elevated legrest, complete assembly, each |
| E1007 | Wheelchair accessory, power seating system, combination tilt & recline, with mechanical sheer reduction |
| E1012 | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete assembly, any type , each |
| E1028 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory |
| E1161 | Manual adult size wheelchair, includes tilt in space |
| E1225 | Wheelchair accessory, manual, semi-reclining back (15 - 80 degrees), each |
| E1226 | Wheelchair accessory, manual, fully reclining back (80 degrees or more) each |
| E1230 | Power operated vehicle, 3 or 4 wheel non-highway |
| E2201 | Manual wheelchair accessory, nonstandard seat frame, width greater than 20 inches but less than 24 inches |
| E2209 | Accessory, arm trough, with or without hand support, each |
| E2211 | Manual wheelchair accessory, pneumatic propulsion tire, any size, each |
| E2213 | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each |
| E2231 | Manual wheelchair accessory, solid seat support base (replaces sling seat) includes any type of mounting hardware |
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and 2 or more power seating system motors, including all related electronics, indicator features, mechanical function selection switch, and fixed mounting hardware |
| E2313 | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each |
| E2361 | Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g.: gel cell, absorbed glassmat |
| E2374 | Power wheelchair accessory, hand or chin control interface, standard remote joystick, (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only |
| E2377 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware |
| E2378 | Power wheelchair component, actuator, replacement only |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width is less than 22 inches, any height, including any type of mounting hardware. |

| *Code* | *Description* |
|---|---|
| E2622 | Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth |
| E2624 | Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth |
| K0002 | Standard hemi (low-seat) wheelchair |
| K0004 | High strength, lightweight wheelchair |
| K0007 | Extra heavy duty wheelchair |
| K0019 | Arm pad, replacement only, each |
| K0040 | Adjustable angle footplate, each |
| K0108 | Wheelchair component or accessory not otherwise specified |
| K0195 | Elevating wheelchair legrests, pair |
| K0822 | Power wheelchair, group 2 standard, sling/solid seat/back, capacity to 300 lbs |
| K0823 | Power wheelchair, group 2 standard, captain's chair, capacity to 300 lbs |
| K0825 | Power wheelchair, group 2 heavy-duty, captain's chair, capacity 301 to 450 lbs. |
| K0861 | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, capacity up to 300 lbs. |
| L3908 | Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off the shelf. |

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself. except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered and our plan won’t pay for them.

The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 9, Section 5.3.)

**Not covered under any condition**

| Services not covered by Medicare | 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<br>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance |
| **Custodial care**<br>Custodial care is personal care that doesn't 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**<br>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<br>(Go to 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 |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **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 help, including light housekeeping or light meal preparation** | Not covered under any condition |
| **Naturopath services (uses natural or alternative treatments)** | Not covered under any condition |
| **Non-routine dental care** | Dental care required to treat illness or injury may be covered as inpatient or outpatient care |
| **Orthopedic shoes or supportive devices for the feet** | Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease |
| **Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television** | Not covered under any condition |
| **Private room in a hospital** | Covered only when medically necessary |
| **Reversal of sterilization procedures and or non-prescription contraceptive supplies** | Not covered under any condition |
| **Routine chiropractic care** | Manual manipulation of the spine to correct a subluxation is covered<br>Certain Evaluation and Management services are covered. See Chiropractic Services in the Chapter 4 Benefit Chart and the List of Excluded Services below. |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Routine dental care, such as cleanings, fillings, or dentures** | Limited coverage through LIBERTY Dental Plan. See "Dental Services" on the medical benefit chart in Chapter 4 for covered services |
| **Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids** | Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Limited coverage for routine eye exam and eyewear through EyeMed. See "Supplemental Vision" on the medical benefits chart in Chapter 4 for covered services. |
| **Routine foot care** | Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes) |
| **Routine hearing exams, hearing aids, or exams to fit hearing aids** | Routine hearing exams are covered. Limited coverage for hearing aid evaluation exam and hearing aids/fitting 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 without preauthorization, when preauthorization is required for getting that service (Chapter 4 gives a definition of preauthorization and tells which services require preauthorization 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.

- Contraceptive devices and insertion and removal of contraceptive devices are not covered (such as an IUD).
- 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). (Please see dental benefits, limitations and exclusions under the dental benefit below.)
- Services required by a third party. Examples of non-covered services are physical examinations that are not medically necessary, such as those required by employment, insurance, licensing, marriage, and court-ordered examinations.
- Benefits provided for any loss for which mandatory automobile no fault benefits are recovered or recoverable including benefits which would have been recoverable except for the fact that a timely claim was not filed by the Member or by a health care provider.
- Services provided after your membership in Independent Health’s Medicare Passport Connect (PPO) 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, such as wheelchair ramps.

- Services provided by a physician or other practitioner who has been precluded by Medicare, except for emergency and urgently needed services.
- With limited exceptions, services provided by an individual who has been sanctioned by CMS or has formally been precluded from the Medicare Program.
- Durable Medical Equipment coverage for items/devices that are not appropriate for use in the member's home environment. Please see Chapter 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.
- 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.
- Electric Hospital Beds: A fully electric bed and accessories and parts are not covered. This is an electric bed that has a height adjustment feature as well as electric head and foot adjustment mechanism.
- Oscillating, circulating, and Stryker frame hospital beds.
- Hospital bed accessory; board, table, or support device, any type.
- Compression stockings, with the exception of these codes A6552, A6554, A6583, A6531, A6532, A6534, A6535 and A6545, these are limited to 6 pairs (12 individual stockings) per year cumulative total. Additionally, we match Original Medicare to cover compression garments to treat lymphedema.
- Post Mastectomy Bras: Limited to 4 per year.
- Routine Foot Care is not covered except for members with certain medical conditions affecting the lower limbs. Our coverage for routine foot care matches Original Medicare.

- Chiropractic services other than the manual subluxation of the spine are not covered with the exception of the following Evaluation and management codes: 99202, 99203, 99204, 99211, 99212, 99213. This includes but is not limited to office visits and radiological services.
- We do not cover 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.
- Items and services that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.
- Items that are primarily and customarily used for a nonmedical purpose, such as room heaters, humidifiers, dehumidifiers, air conditioners, and air purifiers are not covered.
- Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as slings, elevators, stairway elevators, and posture chairs, do not constitute medical equipment and are not covered. Similarly, physical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature and are not covered.
- Dialysis outside of the United States.
- 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.

**LIBERTY Dental Plan Exclusions:**

The following dental services are excluded under the plan:

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

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

| CDT Code | Description | In Network Member Responsibility | Out of Network Member Responsibility | Limitations |
|---|---|---|---|---|
| | **Diagnostic Services** | | | |
| D0120 | Periodic oral evaluation | 0% | 0% | 2 of (D0120-D0180) every calendar year |
| D0140 | Limited oral evaluation | 0% | 0% | |
| D0150 | Comprehensive oral evaluation | 0% | 0% | |
| D0160 | Oral evaluation, problem focused | 0% | 0% | |
| D0170 | Re-evaluation, limited, problem focused | 0% | 0% | |
| D0171 | Re-evaluation, post operative office visit | 0% | 0% | |
| D0180 | Comprehensive periodontal evaluation | 0% | 0% | |
| D0210 | Intraoral, comprehensive series of radiographic images | 0% | 0% | 1 of (D0210, D0330) every 3 calendar years |
| D0220 | Intraoral, periapical, first radiographic image | 0% | 0% | |
| D0230 | Intraoral, periapical, each add 'l radiographic image | 0% | 0% | |
| D0240 | Intraoral, occlusal radiographic image | 0% | 0% | 2 (D0240) every calendar year |

| | | | | |
|---|---|---|---|---|
| D0270 | Bitewing, single radiographic image | 0% | 0% | 2 of (D0270-D0274) every calendar year |
| D0272 | Bitewings, two radiographic images | 0% | 0% | |
| D0273 | Bitewings, three radiographic images | 0% | 0% | |
| D0274 | Bitewings, four radiographic images | 0% | 0% | |
| D0277 | Vertical bitewings, 7 to 8 radiographic images | 0% | 0% | 1 (D0277) every 3 calendar years |
| D0330 | Panoramic radiographic image | 0% | 0% | 1 of (D0210, D0330) every 3 calendar years |
| | **Preventive Services** | | | |
| D1110 | Prophylaxis, adult | 0% | 0% | 2 of (D1110, D4346, D4910) every calendar year |
| D1206 | Topical application of fluoride varnish | 0% | 0% | 2 (D1206) every calendar year |
| D1208 | Topical application of fluoride, excluding varnish | 0% | 0% | 1 (D1208) every calendar year |
| | **Restorative Services** | | | |
| D2140 | Amalgam, one surface, primary or permanent | 50% | 50% | 1 of (D2140-D2335, D2391-D2394) every 3 calendar years per surface per tooth |
| D2150 | Amalgam, two surfaces, primary or permanent | 50% | 50% | |
| D2160 | Amalgam, three surfaces, primary or permanent | 50% | 50% | |

| | | | | |
|---|---|---|---|---|
| D2161 | Amalgam, four or more surfaces, primary or permanent | 50% | 50% | |
| D2330 | Resin-based composite, one surface, anterior | 50% | 50% | |
| D2331 | Resin-based composite, two surfaces, anterior | 50% | 50% | |
| D2332 | Resin-based composite, three surfaces, anterior | 50% | 50% | |
| D2335 | Resin-based composite, four or more surfaces | 50% | 50% | |
| D2390 | Resin-based composite crown, anterior | 50% | 50% | 1 (D2390) every 3 calendar years per tooth |
| D2391 | Resin-based composite, one surface, posterior | 50% | 50% | 1 of (D2140-D2335, D2391-D2394) every 3 calendar years per surface per tooth |
| D2392 | Resin-based composite, two surfaces, posterior | 50% | 50% | |
| D2393 | Resin-based composite, three surfaces, posterior | 50% | 50% | |
| D2394 | Resin-based composite, four or more surfaces, posterior | 50% | 50% | |
| D2710 | Crown, resin-based composite (indirect) | 50% | 50% | 1 of (D2710-D2794) every 5 calendar years per tooth |
| D2712 | Crown, $^{3}/_{4}$ resin-based composite (indirect) | 50% | 50% | |
| D2720 | Crown, resin with high noble metal | 50% | 50% | |

| | | | | |
|---|---|---|---|---|
| D2721 | Crown, resin with predominantly base metal | 50% | 50% | |
| D2722 | Crown, resin with noble metal | 50% | 50% | |
| D2740 | Crown, porcelain/ceramic | 50% | 50% | |
| D2750 | Crown, porcelain fused to high noble metal | 50% | 50% | |
| D2751 | Crown, porcelain fused to predominantly base metal | 50% | 50% | |
| D2752 | Crown, porcelain fused to noble metal | 50% | 50% | |
| D2780 | Crown, ¾ cast high noble metal | 50% | 50% | |
| D2781 | Crown, ¾ cast predominantly base metal | 50% | 50% | |
| D2782 | Crown, ¾ cast noble metal | 50% | 50% | |
| D2783 | Crown, ¾ porcelain/ceramic | 50% | 50% | |
| D2790 | Crown, full cast high noble metal | 50% | 50% | |
| D2791 | Crown, full cast predominantly base metal | 50% | 50% | |
| D2792 | Crown, full cast noble metal | 50% | 50% | |
| D2794 | Crown, titanium and titanium alloys | 50% | 50% | |
| D2952 | Post and core in addition to crown, indirectly fabricated | 50% | 50% | 1 of (D2952, D2954) every 5 calendar years per tooth |

| | | | | |
|---|---|---|---|---|
| D2953 | Each additional indirectly fabricated post, same tooth | 50% | 50% | 1 (D2953) every 5 calendar years per tooth |
| D2954 | Prefabricated post and core in addition to crown | 50% | 50% | 1 of (D2952, D2954) every 5 calendar years per tooth |
| | **Endodontic Services** | | | |
| D3221 | Pulpal debridement, primary and permanent teeth | 50% | 50% | 1 (D3221) in a lifetime per tooth |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | 50% | 50% | 1 of (D3310-D3330) in a lifetime per tooth |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | 50% | 50% | |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | 50% | 50% | |
| D3331 | Treatment of root canal obstruction; non-surgical access | 50% | 50% | 1 (D3331) in a lifetime per tooth |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth | 50% | 50% | 1 (D3332) in a lifetime per tooth |
| | Endodontic Services (continued) | | | |
| D3333 | Internal root repair of perforation defects | 50% | 50% | 1 (D3333) in a lifetime per tooth |

| | | | | |
|---|---|---|---|---|
| D3346 | Retreatment of previous root canal therapy, anterior | 50% | 50% | 1 of (D3346-D3348) in a lifetime per tooth |
| D3347 | Retreatment of previous root canal therapy, premolar | 50% | 50% | |
| D3348 | Retreatment of previous root canal therapy, molar | 50% | 50% | |
| | Periodontal Services | | | |
| D4341 | Periodontal scaling and root planing, four or more teeth per quadrant | 50% | 50% | 1 of (D4341, D4342)every 2 calendar years per site/per quadrant, no more than 2 quads allowed per date of service |
| D4342 | Periodontal scaling and root planing, one to three teeth per quadrant | 50% | 50% | |
| D4346 | Scaling in presence of moderate or severe inflammation, full mouth after evaluation | 50% | 50% | 2 of (D1110, D4346, D4910) every calendar year |
| D4355 | Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit | 50% | 50% | 1 (D4355) every 3 calendar years |
| D4910 | Periodontal maintenance | 50% | 50% | 2 of (D1110, D4346, D4910) every calendar year |
| | Removable Prosthodontics Services | | | |

| | | | | |
|---|---|---|---|---|
| D5110 | Complete denture, maxillary | 50% | 50% | 1 of (D5110-D5283) every 5 calendar years per arch |
| D5120 | Complete denture, mandibular | 50% | 50% | |
| D5130 | Immediate denture, maxillary | 50% | 50% | |
| D5140 | Immediate denture, mandibular | 50% | 50% | |
| D5211 | Maxillary partial denture, resin base | 50% | 50% | |
| D5212 | Mandibular partial denture, resin base | 50% | 50% | |
| D5213 | Maxillary partial denture, cast metal, resin base | 50% | 50% | |
| D5214 | Mandibular partial denture, cast metal, resin base | 50% | 50% | |
| D5221 | Immediate maxillary partial denture, resin base | 50% | 50% | |
| D5222 | Immediate mandibular partial denture, resin base | 50% | 50% | |
| D5223 | Immediate maxillary partial denture, cast metal framework, resin denture base | 50% | 50% | |
| D5224 | Immediate mandibular partial denture, cast metal framework, resin denture base | 50% | 50% | |

| | | | | |
|---|---|---|---|---|
| D5225 | Maxillary partial denture, flexible base | 50% | 50% | |
| D5226 | Mandibular partial denture, flexible base | 50% | 50% | |
| D5282 | Removable unilateral partial denture, one piece cast metal, maxillary | 50% | 50% | |
| D5283 | Removable unilateral partial denture, one piece cast metal, mandibular | 50% | 50% | |
| D5410 | Adjust complete denture, maxillary | 50% | 50% | 1 of (D5410-D5422) every calendar year per arch |
| D5411 | Adjust complete denture, mandibular | 50% | 50% | |
| D5421 | Adjust partial denture, maxillary | 50% | 50% | |
| D5422 | Adjust partial denture, mandibular | 50% | 50% | |
| D5511 | Repair broken complete denture base, mandibular | 50% | 50% | 1 of (D5511, D5512) every calendar year per arch |
| D5512 | Repair broken complete denture base, maxillary | 50% | 50% | |
| D5520 | Replace missing or broken teeth, complete denture | 50% | 50% | 1 (D5520) every calendar year per arch |
| D5611 | Repair resin partial denture base, mandibular | 50% | 50% | 1 of (D5611-D5622) every calendar year per arch |

| | | | | |
|---|---|---|---|---|
| D5612 | Repair resin partial denture base, maxillary | 50% | 50% | |
| D5621 | Repair cast partial framework, mandibular | 50% | 50% | |
| D5622 | Repair cast partial framework, maxillary | 50% | 50% | |
| D5630 | Repair or replace broken retentive clasping materials, per tooth | 50% | 50% | 1 (D5630) every calendar year per tooth |
| D5640 | Replace broken teeth, per tooth | 50% | 50% | 1 (D5640) every calendar year per tooth |
| D5650 | Add tooth to existing partial denture | 50% | 50% | 1 (D5650) every calendar year per tooth |
| D5660 | Add clasp to existing partial denture, per tooth | 50% | 50% | 1 (D5660) every calendar year per tooth |
| D5670 | Replace all teeth & acrylic on cast metal frame, maxillary | 50% | 50% | 1 of (D5670, D5671) every 2 calendar years per arch |
| D5671 | Replace all teeth & acrylic on cast metal frame, mandibular | 50% | 50% | |
| D5710 | Rebase complete maxillary denture | 50% | 50% | 1 of (D5710-D5761) every 2 calendar years per arch |
| D5711 | Rebase complete mandibular denture | 50% | 50% | |
| D5720 | Rebase maxillary partial denture | 50% | 50% | |
| D5721 | Rebase mandibular partial denture | 50% | 50% | |

| | | | | |
|---|---|---|---|---|
| D5730 | Reline complete maxillary denture, direct | 50% | 50% | |
| D5731 | Reline complete mandibular denture, direct | 50% | 50% | |
| D5740 | Reline maxillary partial denture, direct | 50% | 50% | |
| D5741 | Reline mandibular partial denture, direct | 50% | 50% | |
| D5750 | Reline complete maxillary denture, indirect | 50% | 50% | |
| D5751 | Reline complete mandibular denture, indirect | 50% | 50% | |
| D5760 | Reline maxillary partial denture, indirect | 50% | 50% | |
| D5761 | Reline mandibular partial denture, indirect | 50% | 50% | |
| | Oral & Maxillofacial Services | | | |
| D7140 | Extraction, erupted tooth or exposed root | 50% | 50% | 1 of (D7140-D7250) per lifetime per tooth |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth | 50% | 50% | |
| D7220 | Removal of impacted tooth, soft tissue | 50% | 50% | |
| D7230 | Removal of impacted tooth, partially bony | 50% | 50% | |
| D7240 | Removal of impacted tooth, completely bony | 50% | 50% | |

| | | | | |
|---|---|---|---|---|
| D7241 | Removal impacted tooth, complete bony, complication | 50% | 50% | |
| D7250 | Removal of residual tooth roots (cutting procedure) | 50% | 50% | |
| D7260 | Oroantral fistula closure | 50% | 50% | 1 (D7260) every 5 calendar years per site/quad |
| | Adjunctive General Services | | | |
| D9110 | Palliative treatment of dental pain, per visit | 50% | 50% | 1 (D9110) every calendar year |
| D9310 | Consultation, other than requesting dentist | 50% | 50% | 1 (D9310) every 6 months |
| D9311 | Consultation with a medical health care professional | 50% | 50% | |
| D9995 | Teledentistry, synchronous; real-time encounter | 0% | 0% | 2 of (D9995, D9996) every calendar year |
| D9996 | Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review | 0% | 0% | |

**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 in excess of the 40 that come with the original purchase
- Costs associated with replacing lost or damaged hearing aids ($250 per hearing aid).

- Hearing aids other than select Starkey models purchased through a Start Hearing network provider.

# CHAPTER 5:
# Using plan coverage for Part D drugs

## SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's 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 (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

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

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

## Section 2.1 Network pharmacies

### Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (https://www.independenthealth.com/DrugList), and/or call Member Services at 1-800-665-1502 (TTY users call 711).

You may go to any of our network pharmacies.

### If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, call Member Services at 1-800-665-1502 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at https://www.independenthealth.com/DrugList.

### Specialized pharmacies

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 difficulty getting Part D drugs in an LTC facility, call Member Services at 1-800-665-1502 (TTY users call 711)
- 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* https://www.independenthealth.com/DrugList or call Member Services at 1-800-665-1502 (TTY users call 711).

## Section 2.2 Our plan's mail-order service

For certain Part D prescription drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis for a chronic or long-term medical condition. These drugs are marked with "EDS" on our Drug Lists, an abbreviation for extended-day supply.

Our plan's mail-order service requires you to order **a 90-day supply, depending on your coverage.** When using a mail-order pharmacy, your medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an additional charge).

To get more information about filling your prescriptions by mail, visit independenthealth.com/Medicare/prescription-coverage or contact Independent Health's Member Services at the phone number listed on the back of this book.

**First-time registration**

You have the option to use ProAct Pharmacy Services or Wegmans Home Delivery Pharmacy for mail-order service. Before using one of these pharmacies for the first time, you should register. You will need to have your member ID number available.

**To register online:**

ProAct:secure.proactrx.com/mail-order/1/

Wegmans Home Delivery: www.wegmans.com/pharmacy

* Please note: Wegmans does offer standard delivery for $1, but Independent Health members enjoy free standard delivery. We recommend calling the number below to register to make sure you receive this benefit.

**To register by phone:**

ProAct: 1-866-287-9885 (TTY: 711)

Wegmans Home Delivery: 1-888-205-8573 (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 an extended-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.
- The pharmacies accept most major credit and debit cards.

**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.
- To make sure you don't run out of medication, remember to reorder at least 14 days before your medication runs out. You may also be able to set up automatic refills to help you stay on track.

**New prescriptions the pharmacy gets directly from your doctor's office.** After the pharmacy gets a prescription from a health care provider, they will contact you to see if you want the medication filled immediately or at a later time. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or stop the new prescription. If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

### Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 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 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 at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Pharmacy Directory* https://www.independenthealth.com/DrugList tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-800-665-1502 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to 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 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at 1-800-665-1502 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- 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.**

If you must use an out-of-network pharmacy, you'll 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. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

## SECTION 3 Your drugs need to be on our plan's Drug List

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

Our plan has a *List of Covered Drugs (formulary).* In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. 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. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

#### Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.

- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

### Section 3.2 Cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of  cost-sharing tiers. In general, the higher the 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 and brand drugs. This is the highest tier.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

### Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Visit our plan's website (https://www.independenthealth.com/DrugList). Your Drug List is called Independent Health's Medicare Advantage 2026 Standard Part D Formulary. The Drug List on the website is always the most current.
- Call Member Services at 1-800-665-1502 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (https://www.myih.com/MyAccount/Pharmacy) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-800-665-1502 (TTY users call 711). 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 Drugs with restrictions on coverage

### Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our 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, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in 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 example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

## Section 4.2 Types of restrictions

**If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug.** Call Member Services at 1-800-665-1502 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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 (go to Chapter 9).

### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we 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 don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-800-665-1502 (TTY users call 711) or on our website https://www.independenthealth.com/DrugList.

### Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.** Our plan's step therapy criteria can be obtained by calling Member Services at 1-800-665-1502 (TTY users call 711) or on our website https://www.independenthealth.com/DrugList.

### 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's 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 you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

**If your drug isn't on the Drug List or is restricted, here are options for what you can do:**

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

### You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan**.**
- **If you were in our plan last year,** we'll 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. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 34-day 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 at 1-800-665-1502 (TTY users call 711).

**During the time when you're 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 2 options:**

**Option 1. You can change to another drug**

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-800-665-1502 (TTY users call 711) 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.

**Option 2. You can ask for an exception**

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

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

### Section 5.1 What to 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 at 1-800-665-1502 (TTY users call 711) 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 our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it.** If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

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

Drugs in our Tier 5 aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

## SECTION 6 Our Drug List can change during the year

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

### 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 regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

### Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**

  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**

  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.

- **Removing 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 take that drug, we'll tell you after we make the change.

- **Making 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 based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

**Changes to the Drug List that don't affect you during this plan year**

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're 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 won't 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 take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll 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 drugs you take that will impact you during the next plan year.

## SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

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

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- 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 requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

**If you get Extra Help** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

## SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will

automatically bill our plan for our share of your drug cost. You need to pay the pharmacy your share of the cost when you pick up your prescription

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

## SECTION 9 Part D drug coverage in special situations

### Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

### Section 9.2 As 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 its residents. If you're 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's part of our network.

Check your *Pharmacy Directory* https://www.independenthealth.com/DrugList to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-800-665-1502 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

### Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** They can help you understand how your current 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 pays first.

**Special note about creditable coverage:**

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

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

**Keep any notices about creditable coverage** because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

### Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting 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

We conduct drug use reviews to help make sure our members get 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 like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar 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're allergic to
- Possible errors in the amount (dosage) of a drug you take

- Unsafe amounts of opioid pain medications

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

## Section 10.1 Drug Management Program (DMP) to help members safely use 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 prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, 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 or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers 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'll 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'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

## Section 10.2 Medication Therapy Management (MTM) program to help members manage 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. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use 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 get 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. 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-800-665-1502 (TTY users call 711)

# CHAPTER 6:
# What you pay for Part D drugs

## SECTION 1 What you pay for Part D drugs

If you're 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, call Member Services at 1-800-665-1502 (TTY users call 711) and ask for the *LIS Rider*.

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 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (https://www.myih.com/MyAccount/Pharmacy), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-800-665-1502 (TTY users call 711).

### Section 1.1 Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our 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 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't 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 are included in your out-of-pocket costs**

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

- The amount you pay for drugs when you're in the following drug payment stages:
    - The Deductible Stage
    - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

**Moving to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

**These payments <u>aren't included</u> in your out-of-pocket costs**

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare

- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and the government-funded health programs such as TRICARE and Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

*Reminder:* If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-800-665-1502 (TTY users call 711).

**Tracking your out-of-pocket total costs**

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

## SECTION 2 Drug payment stages for Independent Health's Medicare Passport Connect (PPO) members

There are **3 drug payment stages** for your drug coverage under Independent Health's Medicare Passport Connect (PPO). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

## SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

### Section 3.1 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's 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 make sure we know about the prescriptions you fill and what you pay.
- **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 won't 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. **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 use a discount card that's not part of our plan's benefit.
- When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
- Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
- If you're 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 make for you.** Payments made by certain other people 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 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 get a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-800-665-1502 (TTY users call 711). Be sure to keep these reports.

## SECTION 4 The Deductible Stage

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription for the year. When you're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is $615. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you have paid $615 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

## SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered 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.

**Our plan has cost-sharing tiers**

Every drug on our plan's Drug List is in one of 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 $35 per month supply of each covered insulin product on this tier.
- **Tier 4 – Non-preferred drug**: Consists of brand and generic drugs. You pay $35 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 our 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 network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A pharmacy that isn't in the plan's network.
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* https://www.independenthealth.com/DrugList.

### Section 5.2 Your costs for a *one-month* supply of a covered drug

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

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 costs for a *one-month* supply of a covered Part D drug**

| **Tier** | **Standard retail in network cost sharing** (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; go to Chapter 5 for details.) (up to a 30-day supply) |
|---|---|---|---|---|
| **Cost-Sharing Tier 1** (Preferred Generics) | 25% coinsurance | Mail order is not available for drugs in Tier 1 for a 30-day supply | 25% coinsurance | 25% coinsurance |
| **Cost-Sharing Tier 2** (Generics) | 25% coinsurance | Mail order is not available for drugs in Tier 2 for a 30-day supply | 25% coinsurance | 25% coinsurance |
| **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 Drugs) | 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** | 25% coinsurance | Mail order is not available for drugs in Tier 5 | 25% coinsurance | 25% coinsurance |

| **Tier** | **Standard retail in network cost sharing** (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; go to Chapter 5 for details.) (up to a 30-day supply) |
|---|---|---|---|---|
| (Specialty Drugs) | | for a 30-day supply | | |

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

Go to Section 8 of this chapter for more information on 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 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're 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 if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're 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're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

### Section 5.4 Your costs for a *long-term* (up to a 90-day) supply of a covered Part D drug

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

**Your costs for a *long-term* supply of a covered Part D drug:**

| Tier | Standard retail cost sharing (in network) (Up to a 90-day supply) | Mail order cost sharing (Up to a 90-day supply) |
|---|---|---|
| **Cost-Sharing Tier 1** (Preferred Generic) | 25% Coinsurance | 25% Coinsurance |
| **Cost-Sharing Tier 2** (Generic) | 25% Coinsurance | 25% Coinsurance |
| **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 2-month supply or $87.50 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

### Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage.

The Part D EOB you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We’ll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

## SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the

calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

## SECTION 7 What you pay for Part D vaccines

**Important message about what you pay for vaccines** – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to our plan's Drug List or call Member Services at 1-800-665-1502 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines 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. Or a provider may give it in the doctor's office.

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

- When you get a vaccine, you may have to pay 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'll be reimbursed the entire cost you paid.

- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

*Situation 1:* You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you 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 vaccine at your doctor's office.

- When you get the vaccine, you may have to pay 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 described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll 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 take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you 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'll be reimbursed the full amount you paid. For other Part D vaccines, you'll 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 for covered medical services or drugs

## SECTION 1 Situations when you should ask us to pay our share for 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 you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

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

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

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

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to

pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
    - If the provider is owed anything, we'll pay the provider directly.
    - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

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

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

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

**3. If you're retroactively enrolled in our plan**

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

If you were retroactively enrolled in our plan and you paid out of pocket for any 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 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 fill a prescription**

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 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. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

**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 the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.
- 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 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. You will not be reimbursed in this situation.
- 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. You will not be reimbursed in this situation.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a coverage decision. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask us to pay you back by *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 got the service, item, or drug**

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (www.independenthealth.com/Portals/0/PDFs/Individuals/IndependentHealthGeneralClaimForm.pdf) or call Member Services at 1-800-665-1502 (TTY users call 711) and ask for the form.

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

For Medical 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

For Dental Claims:
LIBERTY Dental Plan
P.O. Box 15149
Tampa, FL 33684

For Vision Claims:
EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

**If you go to an in-network provider ("par"), the participating provider must submit your claim to us within 90 days of the date you received the service, item, or drug. If you go to an out-of-network provider ("non-par"), you must submit your claim to us within one year of the date you received the service, item, or drug. Please see Section 1.1 for claim details.**

If a non-network provider asks you to pay for covered services, contact us. You should never pay any provider more than what is allowed by Medicare. The non-network provider has a right to get his/her fees, but does not have a right to get them from you.

Ask the non-network provider to bill us first. If you have already paid for the covered services, we will reimburse you for our share of the cost. If you get a bill for the services, you can send the bill to us for payment. We will pay your out-of-network provider for our share of the bill and will let you know what, if anything, you must pay.

If the non-network provider issuing this bill accepts Medicare assignment (agrees to participate in the Medicare program, which you may want to verify prior to receiving services), they must accept our payment – less any applicable co-payment – as payment in full. You would have no responsibility to pay any remaining balance. However, if a provider has chosen to “opt-out” of the Medicare program, Independent Health does not cover items or services provided or medications prescribed by that individual and no Medicare payment can be made to that physician, practitioner, or member directly or on a capitated basis. If you chose to see a physician or practitioner who has opted out of the Medicare program, you must enter into a private contract with the provider. Finally, the entire balance could be your responsibility should the service provided not be a covered benefit under your Evidence of Coverage. **You must submit your medical claim to us within one year of the date you**

**received the service or item and your pharmacy claims within 36 months of the date you received the drug.**

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

# CHAPTER 8:
# Your rights and responsibilities

## SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (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're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-665-1502 (TTY users call 711)

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Independent Health's Member Services Department, 1-800-665-1502, TTY users dial 711. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think you aren't 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're 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 don't require us to get your written permission first. These exceptions are allowed or required by law.

- We're required to release health information to government agencies that are checking on quality of care.
- Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D 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's been shared with others**

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-665-1502 (TTY users call 711).

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**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.

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

As a member of Independent Health's Medicare Passport Connect (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-800-665-1502 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our 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 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 isn't 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 You have the right to know your treatment options and participate in decisions about your care

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

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

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

**You have the right to give instructions about what's to be done if you can't make medical decisions for yourself**

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-800-665-1502 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it’s a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

**If your instructions aren’t followed**

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the New York State Department of Health at 1-716-847-4532. www.health.ny.gov.

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 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're required to treat you fairly.**

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

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

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

- **Call Member Services at 1-800-665-1502 (TTY users call 711)**.
- **Call your local SHIP** at 1-800-701-0501
- **Call Medicare at** 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-665-1502 (TTY users call 711)**.
- **Call your local SHIP** at 1-800-701-0501
- **Contact Medicare**
    - Visit www.Medicare.gov to read the publication Medicare Rights & Protections (available at: (Medicare Rights & Protections)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

## SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-665-1502 (TTY users call 711)

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D 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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must pay our plan premiums.
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.

- If you're 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 stay a member of our 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* our plan service area, you for more than six months can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

# CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

### Section 1.1 Legal terms

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

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

## SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-665-1502 (TTY users call 711) for help.

In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

### State Health Insurance Assistance Program (SHIP)

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

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

### Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). , 24 hours a day, 7 days a week. TTY users call 1-877-486-2048
- Visit www.Medicare.gov

## SECTION 3 Which process to use for your problem

**Is your problem or concern about your benefits or coverage?**

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

**Yes.**

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

**No.**

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

# Coverage decisions and appeals

## SECTION 4 A guide to coverage decisions and appeals

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

### Asking for coverage decisions before you get services

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

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

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

### Making an appeal

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

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

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

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

- **Call Member Services at 1-800-665-1502 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-665-1502 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website atwww.independenthealth.com/medicare.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or other person to be your representative, call Member Services at 1-800-665-1502 (TTY users call 711) and ask for the *Appointment of Representative form*. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.independenthealth.com/medicare.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

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

### Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** 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 information applies to you, call Member Services at 1-800-665-1502 (TTY users call 711). You can also get help or information from your SHIP.

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

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

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

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

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

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

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**

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

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

**Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, go to Sections 7 and 8. Special rules apply to these types of care.

### Section 5.2 How to ask for a coverage decision

**Legal Terms:**

A coverage decision that involves your medical care is called an **organization determination.**

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

**<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.**

**A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days**

**for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:**

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

**If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**

**If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

***For standard coverage decisions we use the standard deadlines.***

**This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.**

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

process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

***For fast coverage decisions we use an expedited timeframe***

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

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

**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're going on to Level 1 of the appeals process.

## Section 5.3 How to make a Level 1 appeal

**Legal Terms:**

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

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

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

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

**Step 2: Ask our plan for an appeal or a fast appeal**

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

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

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

***Deadlines for a fast appeal***

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

***Deadlines for a standard appeal***

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

## Section 5.4 The Level 2 appeal process

**Legal Term:**

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

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

**Step 1: The independent review organization reviews your appeal.**

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

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

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

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

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

### Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request**: If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar

days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.

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

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

**To make this appeal, follow the process for appeals in Section 5.3.** For appeals concerning reimbursement, note:

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

## SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

### Section 6.1 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. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to 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 don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't 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'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **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 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 Asking for an exception

**Legal Terms:**

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd 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 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4.

You can't 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 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you 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 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 can't ask us to change the cost-sharing tier for any drug in Tier 5, "Specialty Tier."
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List *typically* 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're requesting and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception. If you ask us for a tiering exception, we generally *won't* 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 our 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 How to ask for a coverage decision, including an exception

**Legal term:**

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

**<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.**

**Standard coverage decisions** are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get 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 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't 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'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll 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 asked for. We'll answer your complaint within 24 hours of receipt.

**Step 2: Ask for a standard coverage decision or a fast coverage decision.**

Start by calling, writing, or faxing our plan to ask 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 www.independenthealth.com/medicare. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows 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 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason 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 get your request.
    - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
    - If we don't meet this deadline, we're 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 asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

***Deadlines for a standard coverage decision about a drug you didn't get yet***

- We must generally give you our answer **within 72 hours** after we get your request.
    - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.

- If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 get your request.
  - If we don't meet this deadline, we're 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 asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

**Step 4: 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're going to Level 1 of the appeals process.

## Section 6.5 How to make a Level 1 appeal

**Legal Terms:**

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination**.

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

- If you're appealing a decision we made about a drug you didn't get yet, 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 Redetermination Request Form,* which is available on our website www.independenthealth.com/medicare. Include your name, contact information, and information about your claim to help us process 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 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all 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 get your appeal**. We'll give you our answer sooner if your health requires us to.

- If we don’t give you an answer within 72 hours, we’re required to send your request 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 asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we’ll send you 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 didn’t get yet***

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We’ll give you our decision sooner if you didn’t get the drug yet and your health condition requires us to do so.

    - If we don’t give you a decision within 7 calendar days, we’re required to send your request 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 asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.

- **If our answer is no to part or all of what you asked for**, we’ll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.

    - If we don’t meet this deadline, we’re 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 asked for**, we’re also required to make payment to you within **30 calendar days** after we get your request.

- **If our answer is no to part or all of what you asked for**, we’ll send you a written statement that explains why we said no. We’ll 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 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 independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

**Step 2: The independent review organization reviews your appeal.**

- Reviewers at the independent review organization will take a careful look at all the information about 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 gets your appeal request.

***Deadlines for standard appeal***

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

**Step 3: The independent review organization gives you its answer.**

***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent 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 independent review organization **within 72 hours** after we get the decision from the independent 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're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

**What if the independent 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's also called **turning down your appeal**.). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.

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

## SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

### Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-665-1502 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

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

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

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-800-665-1502 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

### Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-800-665-1502 (TTY users call 711). Or call your State Health Insurance Assistance

Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

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

***How can you contact this organization?***

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it 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 at 1-800-665-1502 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

***What happens if the answer is yes?***

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

***What happens if the answer is no?***

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

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

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

## Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about 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 it's decision.**

***If the independent review organization says yes:***

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

***If the independent review organization says no:***

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

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

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

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

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

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

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

### Section 8.1 We'll tell you in advance when your coverage will be ending

**Legal Term:**

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

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

### Section 8.2 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'll 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, call Member Services at 1-800-665-1502 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

**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 aren't 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 got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

**Legal Term:**

**Detailed Explanation of Non-Coverage.** Notice that gives 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll 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 it's decision.**

***What happens if the reviewers say yes?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll 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 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, **you'll 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 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

***What happens if the independent review organization says yes?***

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

***What happens if the independent review organization says no?***

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

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

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

## SECTION 9 Taking your appeal to Levels 3, 4, and 5

### Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

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

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

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

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

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

## Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

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

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

- **If the answer is yes, 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you 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 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 Member Services. Here are examples of the kinds of problems handled by the complaint process.

| Complain | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you got (including care in the hospital)? |
| **Respecting your privacy** | • Did someone not respect your right to privacy or share confidential information? |
| **Disrespect, poor customer service, or other negative behaviors** | • Has someone been rude or disrespectful to you?<br>• Are you unhappy with our Member Services?<br>• Do you feel you're being encouraged to leave our plan? |
| **Waiting times** | • Are you having trouble getting an appointment, or waiting too long to get it?<br>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?<br>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?<br>• Is our written information hard to understand? |

| | |
|---|---|
| **Timeliness**<br>(These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals) | If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:<br>• You asked us for a *fast coverage decision* or a *fast appeal,* and we said no; you can make a complaint.<br>• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.<br>• You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.<br>• 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 called **filing a grievance.**

**Using the process for complaints** is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

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

- **Calling Member Services at 1-800-665-1502 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

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

**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 Chapter 2, Section 1. 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 Benefit Administration 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 Benefit Administration 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.

### Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

*Or*

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

### Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about Independent Health's Medicare Passport Connect (PPO) directly to Medicare. To submit a complaint to Medicare, go

to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

# CHAPTER 10:
# Ending membership in our plan

## SECTION 1 Ending your membership in our plan

Ending your membership in Independent Health's Medicare Passport Connect (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

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

- **The Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - Original Medicare *without* a separate Medicare drug plan.
        - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

**Note:** If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days 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 end in our plan** when your new plan's coverage starts on January 1.

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

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

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

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

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

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

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage

- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

**Enrollment time periods vary** depending on your situation.

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

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

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

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

**If you get Extra Help from Medicare to pay your drug coverage costs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

### Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- C**all Member Services at 1-800-665-1502 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

## SECTION 3 How to end your membership in our plan

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

| To switch from our plan to: | Here's what to do: |
|---|---|
| **Another Medicare health plan** | • Enroll in the new Medicare health plan.<br>• You'll automatically be disenrolled from *Independent Health's Medicare Passport Connect (PPO)* when your new plan's coverage starts. |
| **Original Medicare *with* a separate Medicare drug plan** | • Enroll in the new Medicare drug plan.<br>• You'll automatically be disenrolled from Independent Health's Medicare Passport Connect (PPO) when your new drug plan's coverage starts. |
| **Original Medicare *without* a separate Medicare drug plan** | • **Send us a written request to disenroll.** Call Member Services at *1-800-665-1502* (TTY users call *711*) if you need more information on how to do this.<br>• You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.<br>• You'll be disenrolled from *Independent Health's Medicare Passport Connect (PPO)* when your coverage in Original Medicare starts. |

## 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 starts, you must continue to get your medical items, services and prescription drugs through our plan.

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

## SECTION 5 Independent Health's Medicare Passport Connect (PPO) must end our plan membership in certain situations

**Independent Health's Medicare Passport Connect (PPO) must end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
    - If you move or take a long trip, call Member Services at 1-800-665-1502 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
    - If you've been a member of our plan continuously before January 1999 *and* you were living outside of our service area before January 1999, you're still eligible as long as you haven't moved since before January 1999. However, if you move to another location outside our service area, you'll be disenrolled from our plan
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you don't pay our plan premiums for 90 days.

- If you don’t pay our plan premiums for a period of time established by your group administrator.
    - We must notify you in writing that you have 90 days to pay our plan premium before we end your membership.
- If you’re required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you’ll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-665-1502 (TTY users call 711).

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

Independent Health's Medicare Passport Connect (PPO) isn’t allowed to ask you to leave our plan for any health-related reason.

**What should you do if this happens?**

If you feel you’re being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

# CHAPTER 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 (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

## SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 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 www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Member Services 1-800-665-1502 (TTY users call 711). 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 Passport Connect (PPO), 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.

- 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.

- 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.
- 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.
- 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

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

**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 got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

**Balance Billing –** When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Independent Health's Medicare Passport Connect (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our 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 can't be copied exactly, so alternative forms are called biosimilars. (Go to "**Original Biological Product"** and **"Biosimilar"**).

**Biosimilar** – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

**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.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100for Part D covered drugs during the covered year. During this payment stage, our 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-SNP) -** C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

**Combined Maximum Out-of-Pocket Amount** – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. Go to Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

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

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

**Copayment (or copay)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, 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 gotten. (This is in addition to our plan's monthly plan premium.) Cost sharing includes any combination of the following 3 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 gotten; 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 gotten.

**Cost-Sharing Tier –** Every drug on the list of covered drugs is in one of 5 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 our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our 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 the prescription drugs covered by our plan.

**Covered Services** – The term we use in this EOC to mean all 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**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're 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 our 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.

**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 people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

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

**Durable Medical Equipment (DME)** – Certain medical equipment that 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're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that 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.

**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 isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

**Formulary** – List of covered drugs.

**Generic Drug** – A prescription drug that is approved by the 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 doesn't involve coverage or payment disputes.

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

**Hospice** - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must

provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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

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

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

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

**In-Network Maximum Out-of-Pocket Amount** – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

**Institutional Special Needs Plan (I-SNP)** – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

**Institutional–Equivalent Special Needs Plan (IE-SNP)** – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

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

**List of Covered Drugs (formulary or Drug List)** – A list of prescription drugs covered by our plan.

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

**Manufacturer Discount Program** – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

**Maximum Fair Price** – The price Medicare negotiated for a selected drug.

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

**Medically Accepted Indication –** A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

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

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

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

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

**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.

**Medication Therapy Management (MTM) program** – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

**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**.

**Open 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.

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

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

**Original Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 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 doesn't 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 aren't covered by our plan unless certain conditions apply.

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

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

**Out-of-Pocket Threshold** – The maximum amount you pay out of pocket for Part D drugs.

**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 get both their Medicare and Medicaid benefits through our plan.

**Part C –** Go to 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 plan 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're first eligible to join a Part D plan.

**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 gotten from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten 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 services -** Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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

**Prior Authorization** – Approval in advance to get services and/or certain drugs based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don’t need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

**Prosthetics and Orthotics** – Medical devices including, but aren’t 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 a drug 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 written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

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

**Selected Drug** – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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

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

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

**Urgent medical service facility, in-network** - A network provider which is an alternative site of service which is for the purpose of managing acute, non-life-threatening conditions other than in an emergency room of a hospital during non-traditional physician office hours; is not a substitute for routine care provided in the primary care physician's office or as a substitute

for care for a medical emergency at the emergency room of a hospital; is equipped to accommodate minor outpatient procedures; provides ancillary services such as laboratory and radiology; directs you to receive any necessary follow-up care from your primary care physician and has entered into an agreement with Independent Health to provide such care to you.

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

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
- 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.

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Independent Health

If you have a question about covered drugs, please call 1-800-665-1502 or visit https://www.independenthealth.com/DrugList to access our online formulary. If you would like a formulary mailed to you, you may call the number above, request one at the website link provided above, or email medicareservice@servicing.independenthealth.com.

**Notice of Nondiscrimination**

**Discrimination is Against the Law**
Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

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

If you need these services, contact Independent Health's Member Services Department. If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 711, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Form Approved
OMB# 0938-1421

Independent Health

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-665-1502 (TTY: 711) or speak to your provider.

**Español (Spanish):** ATENCIÓN: Si habla español, hay servicios de asistencia lingüística disponibles para usted de forma gratuita. También están disponibles, sin cargo adicional, los auxilios y servicios apropiados para proporcionar información en formatos accesibles. Llame al 1-800-665-1502 (TTY: 711) o hable con su proveedor.

中文 (Simplified Chinese): 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-665-1502（文本电话：711）或咨询您的服务提供商。

台語 (Traditional Chinese): 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-665-1502（TTY：711）或與您的提供者討論。

РУССКИЙ (Russian): ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-665-1502 (TTY: 711) или обратитесь к своему поставщику услуг.

יידיש (Yiddish): נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעבטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פּראַוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען זענען אויך בנימצא פריי. רופן 1-800-665-1502 (TTY: 711) אָדער רעדן מיט דיין טרעגער.

**বাংলা (Bengali):** মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-665-1502 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

**Kreyòl Ayisyen (Haitian Creole):** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-665-1502 (TTY: 711) oswa pale avèk founisè w la.

Y0042_C9231_C

Form CMS-10802

(Expires 12/31/25)

**한국어 (Korean):** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-665-1502 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**العربية (Arabic):** تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-665-1502 (711) أو تحدث إلى مقدم الخدمة.

**Italiano (Italian):** ATTENZIONE: Se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti per te. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il 1-800-665-1502 (TTY: 711) o parla con il tuo fornitore.

**Français (French):** ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-665-1502 (TTY: 711) ou parlez à votre prestataire.

POLSKI (Polish): UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-665-1502 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

**اردو (Urdu):** توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-800-665-1502 (TTY:711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

SHQIP (Albanian): VINI RE: Nëse flisni [shqip], shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-665-1502 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

**ਪੰਜਾਬੀ (Punjabi):** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-665-1502 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

Independent Health

**Independent Health's Medicare Passport Connect (PPO) Member Services**

| Method | Member Services Contact Information |
|---|---|
| **Call** | 1-716-250-4401 or toll free at 1-800-665-1502<br>Calls to these numbers are free.<br>Hours of operation (Eastern time):<br>October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m.<br>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.<br>Member Services 1-800-665-1502 (TTY users call 711) also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br>October 1 – March 31: Monday - Sunday, 8 a.m. - 8 p.m.<br>April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. |
| **Fax** | **716-631-1039** |
| **Write** | 511 Farber Lakes Drive, Buffalo, NY 14221<br>medicareservice@servicing.independenthealth.com |
| **Website** | www.independenthealth.com/medicare |

Health Insurance Information, Counseling and Assistance Program **(HIICAP) (New York's SHIP)** HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

| Method | Contact Information |
|---|---|
| **Call** | HIICAP Hot Line: 1-800-665-1502 |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **Write** | Health Insurance Information, Counseling, and Assistance Program<br>New York State Office for the Aging<br>2 Empire State Plaza<br>Albany, New York 12223-1251 |
| **Website** | www.aging.ny.gov |

*PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*