Independence

**January 1 – December 31, 2026**

# Evidence of Coverage for 2026:

## Your Medicare Health Benefits and Services as a Member of Personal Choice 65℠ PPO

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

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

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

**For questions about this document, call our Member Help Team at 1-888-879-4293. (TTY/TDD users call 711). Hours are seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. This call is free.**

This plan, Personal Choice 65, is offered by QCC Insurance Company, a subsidiary of Independence Blue Cross, LLC ("IBX"). (When this *Evidence of Coverage* says "we," "us," or "our," it means QCC Insurance Company. When it says "plan" or "our plan," it means Personal Choice 65.)

To receive this document in an alternate format such as braille, data CD, large print, or audio, please contact our Member Help Team.

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

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



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

## Table of Contents

# CHAPTER 1:

*Get started as a member*

# SECTION 1 You're a member of Personal Choice 65

## Section 1.1 You're enrolled in Personal Choice 65, which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Personal Choice 65. Our plan covers all Part A and Part B services. However, cost-sharing and provider access in this plan are different from Original Medicare.

Personal Choice 65 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. This plan doesn't include Part D drug coverage.

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

This *Evidence of Coverage* is part of our contract with you about how Personal Choice 65 covers your care. Other parts of this contract include your enrollment form 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 Personal Choice 65 between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Personal Choice 65 after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

**Medicare must approve our plan each year**

Medicare (the Centers for Medicare & Medicaid Services) must approve Personal Choice 65 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 requirement

## 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 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 Personal Choice 65

Personal Choice 65 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 plan service area. The service area is described below.

Our service area includes all 50 states.

If you move out of our plan's service area, you can't stay a member of this plan. Call our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711) to see if we have a plan in

your new area. When you move, you will 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, its also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

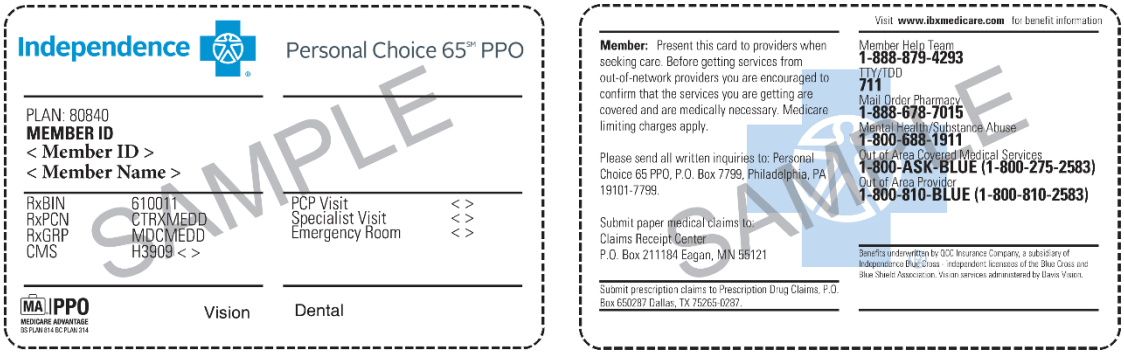
### Section 2.3 U.S. citizen or lawful presence

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 Personal Choice 65 if you're not eligible to stay a member of our plan on this basis. Personal Choice 65 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. You should also show the provider your Medicaid card, if you have one. Sample 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 Personal Choice 65 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 our Member Help Team at 1-888-879-4293 (TTY/TTD users call 711) right away and we will send you a new card.

### Section 3.2 Provider Directory

The *Provider Directory* www.ibxmedicare.com/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.

Get the most recent list of providers and suppliers on our website at www.ibxmedicare.com/directory.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from our Member Help Team at 1-888-879-4293 (TTY/TTD users call 711) Requested paper *Provider Directo*ries will be mailed to you within 3 business days.

## SECTION 4 Your monthly costs for Personal Choice 65

Your costs may include the following:

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

### Section 4.1 Plan premium

As a member of our plan, you or your Employer or Union pay the monthly plan premium.

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about the plan premium.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-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 you or your Employer or Union paying the monthly plan premium, **you or your Employer or Union 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 5 More information about your monthly premium

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

There are five ways you can pay our plan premium.

**Option 1: Paying by check**

Direct Pay – Your monthly premium bill is sent to your home. You should write your check payable to QCC Insurance Company (not payable to CMS or HHS) and send it directly to us.

You're enrolled in a plan that charges a monthly premium, and you should be aware of the following:

- You'll receive a bill around the 25th day of every month.
- Your premium is due on the 15th day of every month, unless stated otherwise on your bill.
- Your bank may apply a penalty to your account if your check is returned because of insufficient funds.

Checks should be mailed to:

| **For Individually Billed (Member Direct Pay):** | **For Group Administrators:** |
|---|---|
| Independence Blue Cross<br>P.O. Box 825420<br>Philadelphia, PA 19182-5420 | Independence Blue Cross<br>P.O. Box 825439<br>Philadelphia, PA 19182-5439 |

Payments can also be made in person at:

Independence LIVE
1919 Market Street, 2nd Floor
Philadelphia, PA 19103
8 a.m. to 4 p.m., Monday through Friday

**Note**: The Independence LIVE hours are subject to change.

**Note**: Independence LIVE accepts payments made by checks and money orders. We cannot accept cash payments.

Please do not write any notes or correspondence to us on your premium bill.

**Option 2: Pay your premium on our website**

Direct Pay members who have registered on our website at www.ibx.com/login will be able to view and/or pay their invoices directly online when they log in at www.ibx.com/login. You can pay directly from your bank account through our e-Bill system.

To schedule payments, the user must create a bank account profile and then select a payment date. Please note that payments must be scheduled on business days. They can't be scheduled on weekends or holidays. In addition, all payments must be scheduled at least two business days prior to the payment due date. If a payment date isn't chosen, the calendar will default to the first available payment date. You can also choose to have your payment drawn from either a checking or savings account. Payments may be scheduled for a one-time withdrawal or on a recurring basis. The frequency of recurring withdrawals may be determined by the member (i.e., monthly, bimonthly, quarterly, etc.). Since our plan's members are invoiced monthly, we recommend that you schedule your recurring payments for once each month.

You're excluded from this option if you have selected the following payment options: Electronic Funds Transfer (EFT) (Option 3), direct payment deductions from your monthly Railroad Retirement Board benefit check (Option 4), or direct payment deductions from your monthly Social Security check (Option 5).

For more information regarding this payment option, please contact our Member Help Team.

**Option 3: Have your monthly plan premium automatically withdrawn from your bank account**

Electronic Funds Transfer (EFT) – A fully automatic, computerized way to have your monthly premium payment deducted directly from your bank account.

EFT deductions occur monthly between the 5th and the 15th day of each month. The deduction will not occur on a weekend or bank holiday. At that time, the deduction occurs on the next business day.

If you're interested in the EFT option, please contact our Member Help Team.

After completing the EFT application, please continue to pay your monthly premium directly to the plan until you receive confirmation of enrollment in the EFT program. To avoid overpayment, you can specify a start date for the EFT when you select it as your payment method. If an over payment does occur, you can request that the amount be refunded or applied as a credit towards your next month's payment. The automated EFT may take up to one to two billing cycles to go into effect from the date of your request for enrollment.

**Option 4: Have your plan premium taken out of your monthly Railroad Retirement Board (RRB) benefit check**

You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) benefit check. For more information on how to pay your plan premium this way, please contact our Member Help Team. We will be happy to help you set this up.

**Option 5: Have your plan premium taken out of your monthly Social Security check**

**Changing the way you pay your plan premium.** If you decide to how you 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 that your plan premium is paid on time. To change your payment method, please contact our Member Help Team or log in at www.ibx.com/login to change it directly. If you are new to your plan, you may indicate your payment choice on the enrollment form or call our Member Help Team for assistance.

**If you have trouble paying your premium**

Your plan premium is due in our office by the 15th of the month. If we don't get your payment by the 28th of the month, we'll send you a notice letting you know that your account has a balance due.

If you have trouble paying your premium on time, call our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711) to see if we can direct you to programs that will help with your costs.

## 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, tell we'll you in September and the new premium will take effect on January 1.

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

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

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

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

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about 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 our Member Help Team at 1-888-718-3333 (TTY/TDD 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 is not listed, call our Member Help Team at 1-888-879-4293 (TTY/TDD 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") and pays up to the limits of its coverage. The one 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 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 Personal Choice 65 contacts

For help with claims, billing or member card questions, call or write to our Personal Choice 65 Member Help Team at 1-888-879-4293 (TTY/TDD users call 711). We'll be happy to help you.

| | Member Help Team – Contact Information |
|---|---|
| **Call** | 1-888-879-4293<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.<br>Our Member Help Team 1-888-879-4293 (TTY users call 711) also has free language interpreter services for non-English speakers. |
| **TTY/TDD** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **Fax** | 1-888-289-3029<br>215-238-7960 |
| **Write** | Personal Choice 65<br>PO Box 7799<br>Philadelphia, PA 19101-7799 |
| **Website** | www.ibxmedicare.com |

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7.

| | Coverage Decisions for Medical Care – Contact Information |
|---|---|
| **Call** | 1-800-ASK-BLUE (1-800-275-2583)<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **TTY/TDD** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **Fax** | 1-888-289-3029<br>215-238-7960 |
| **Write** | Personal Choice 65<br>Clinical Precertification<br>1901 Market Street<br>Philadelphia, PA 19103 |
| **Website** | www.ibxmedicare.com |

### How to ask for an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making appeals about your medical care, see Chapter 7.

| | Appeals for Medical Care – Contact Information |
|---|---|
| **Call** | 1-888-879-4293<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **TTY/TDD** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **Fax** | 1-888-289-3008<br>215-988-2001 |
| **Write** | Personal Choice 65<br>Medicare Member Appeals Unit<br>PO Box 13652<br>Philadelphia, PA 19101-3652 |
| **Website** | www.ibxmedicare.com |

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

| | Complaints about Medical Care – Contact Information |
|---|---|
| **Call** | 1-888-879-4293<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **TTY/TDD** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **Fax** | 1-888-289-3008<br>215-988-2001 |
| **Write** | Personal Choice 65<br>Medicare Member Appeals Unit<br>PO Box 13652<br>Philadelphia, PA 19101-3652 |
| **Medicare website** | To submit a complaint about Personal Choice 65 directly to Medicare, go to www.Medicare.gov/my/medicare-complaint. |

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

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

| | **Payment Requests – Contact Information** |
|---|---|
| **Call** | 1-888-879-4293<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **TTY/TDD** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. |
| **Fax** | 1-888-289-3029<br>215-238-7960 |
| **Write** | Independence Blue Cross<br>Claims Receipt Center<br>PO Box 211184<br>Eagan, MN 55121 |
| **Website** | www.ibxmedicare.com |

## SECTION 2 Get help from Medicare

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

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

| | **Medicare – Contact Information** |
|---|---|
| **Call** | 1-800-MEDICARE (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 |
| **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 preventative 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<br>ny complaints you have about Personal Choice 65.<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 Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

PA MEDI 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.

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

| Method | PA MEDI (Pennsylvania SHIP) – Contact Information |
|---|---|
| **Call** | 1-800-783-7067 |
| **Write** | Pennsylvania Medicare Education and Decision Insight (PA MEDI)<br>Commonwealth of Pennsylvania Department of Aging<br>555 Walnut Street, 5th Floor<br>Harrisburg, PA 17101-1919 |
| **Website** | www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx |

## SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare beneficiaries in each state. For Pennsylvania, the Quality Improvement Organization is called Livanta.

Livanta 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. Livanta is an independent organization. It is not connected with our plan.

Contact Livanta in any of these situations:

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

| | **Livanta: (Pennsylvania's Quality Improvement Organization) – Contact Information** |
|---|---|
| **Call** | 1-888-396-4646<br>Monday through Friday, 9 a.m. to 5 p.m., and Saturday and Sunday, 11 a.m. to 3 p.m. 24-hour voicemail service is available. |
| **TTY** | 1-888-985-2660<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | Livanta LLC<br>BFCC-QIO Program<br>10820 Guilford Road<br>Suite 202<br>Annapolis Junction, MD 20701-1105 |
| **Website** | www.livantaqio.com |

## SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

| M | Social Security – Contact Information |
|---|---|
| **Call** | 1-800-772-1213<br>Calls to this number are free.<br>Available 8 a.m. to 7 p.m., 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 a.m. to 7 p.m., Monday through Friday. |
| **Website** | www.SSA.gov |

## SECTION 6 Medicaid

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

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

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

**Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

**Qualifying Individual (QI):** Helps pay Part B premiums

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

To find out more about Medicaid and Medicare Savings Programs, contact the Pennsylvania Department of Public Welfare – Office of Medical Assistance Programs (OMAP).

| **M** | **Pennsylvania Department of Public Welfare<br>Office of Medical Assistance Programs (OMAP) – Contact Information** |
|---|---|
| **Call** | 1-800-537-8862 |
| **Write** | Pennsylvania Department of Public Welfare<br>Office of Medical Assistance Programs (OMAP)<br>Health and Welfare Building, Room 515<br>PO Box 2675<br>Harrisburg, PA 17105-2675 |
| **Website** | www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx |

## SECTION 7 Railroad Retirement Board (RRB)

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

| | 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 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday.<br>Press "1" to access the automated RRB Help Line 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** | www.RRB.gov/ |

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or our Member Help Team at 1-888-678-7009 (TTY/TDD users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

# 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, use the *Medical Benefits Chart* in Chapter 4.

## Section 1.1 Network providers and covered services

**Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.

**Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.

**Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

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

As a Medicare health plan, Personal Choice 65 must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Personal Choice 65 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 is 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.ibxmedicare.com/directory.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. 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 may choose a Primary Care Provider (PCP) to provide and oversee your medical care

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

When you become a member of Personal Choice 65, you may select a plan physician as your primary care provider. All primary care providers meet state requirements and are trained to give you basic medical care. A primary care provider is usually a family or general practitioner or an internist who knows the plan's network and can guide you to a plan specialist when needed. You do not need your primary care provider's approval to visit a specialist. You need prior authorization from our plan to receive some in-network covered services, as outlined in Section 2.2 below.

Your PCP will provide you with basic medical care and help to arrange or coordinate covered services that you receive as a plan member. These covered services include:

- X-rays;
- Therapies
- Care from doctors who are specialists; and
- Follow-up care.

### How to choose a PCP?

As a Personal Choice 65 member, you may select a PCP to coordinate your care. A PCP is not required, but we encourage you to select one.

Whether you already have a PCP or are searching for one, our *Provider/Pharmacy Directory* will help you confirm their in-network status or help you locate one in your plan's network that's best suited for your needs. Our online *Find a Provider* tool can help you find in-network providers (doctor, hospital, and other medical facilities). Our online *Find a Provider* tool is available at www.ibxmedicare.com/providerfinder. There are two ways you can select a PCP:

- To select your PCP online, log in or register at www.ibx.com/login.
- Or call our Member Help Team, who can assist you in finding and selecting a PCP.

Once you select your PCP, you will receive an updated member ID card with your PCP name, phone number, and laboratory information.

### 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.

To change your PCP, call our Member Help Team or log in or register at www.ibx.com/login. The change will be effective the first day of the month following the request for change. If you call, be sure to inform our Member Help Team representative if you are seeing any specialists or receiving covered services that your PCP approved (such as home health services and durable medical equipment). Our Member Help Team representative will then:

- Help you continue to receive specialty care and covered services when you change your PCP;

- Verify that your chosen PCP is accepting new patients; and
- Change your membership record to show the name of your new PCP.

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

You do not need to get a referral from your PCP to see a medical specialist, mental/behavioral health specialist, or other network providers. See section 2.3 for how to get care from specialists and other network providers.

## 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

If you need specialized care, you do not need a referral to see a medical specialist, mental/behavioral health specialist, or other network providers for in-network services. However, you are required to seek approval in advance to get certain procedures or covered services. This is called getting "prior authorization." In the network portion of a PPO, some in-network medical services are covered only if your doctor or the other network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services, but we encourage you to contact us to receive it. Our plan will determine whether the service you are requesting is medically necessary and authorized under our plan rules. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4, Section 2.1.

To find an in-network medical specialist or mental/behavioral health specialist, visit the *Find a Provider* tool at www.ibxmedicare.com/directory.

**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 are assigned to the provider, currently get care from them, or have seen 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. Prior authorization is required in these instances.
- If you find out 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 7).

## 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 in-network or out-of-network providers, as long as the services are covered benefits and are 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 receive. 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 are getting are covered and medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not 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 7 to learn how to make an appeal).
- 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, will 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 5).
- 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 do not 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, and worldwide emergency services outside of the United States.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call us is located on the back of our member ID card.

**Covered services in a medical emergency**

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

The doctors giving you emergency care will 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 was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, 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 an 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 or our plan network is temporarily unavailable.

As a member of our plan, you can receive your care from an in-network or out-of-network urgent care facility at the same cost-sharing amount. See Chapter 4, Section 2.1 for details about copayments. The urgent care facilities in our network can be found in the *Provider/Pharmacy Directory*, on our website at www.ibxmedicare.com/directory, or by calling our Member Help Team. As soon as possible, make sure that our plan has been told about your care. We need to follow up on your care. You or someone else should call to tell us about your care, usually within 48 hours. The number to call us is located on the back of your member ID card.

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

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

You require urgently needed services to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

### 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.ibxmedicare.com, for information on how to get needed care during a disaster.

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

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

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

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

Personal Choice 65 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. If you pay for services once you reach your benefit limit for those services, or for services not covered by Original Medicare, your out-of-pocket expenses will not count toward your out-of-pocket maximum. You can call our Member Help Team when you want to know how much of your benefit limit you have already used.

## 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.

**If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you receive as part of the study.** If you tell us you're in a qualified clinical trial, then you're only responsible for the in-network cost-sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will 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. 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 receive 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 5 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 then 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.prf.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 Areligious 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 that you get that's *not* voluntary or *is required* under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.

- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital and Inpatient Mental Health Care coverage limits apply. Please refer to the Medical Benefits Chart in Chapter 4 for information on these 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 Personal Choice 65, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll transfer ownership of the DME item to you. Call our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711) for more information.

**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 toward these 13 payments.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership 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, Personal Choice 65 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 Personal Choice 65 or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you with 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 will pay for each covered service as a member of Personal Choice 65. This section also gives information about medical services that aren't covered and explains limits on certain services.

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

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

**Copayment:** 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.)

**Deductible:** the amount you must pay for before our plan begins to pay its share.

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

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

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 (MOOP)** is listed in your *Benefit Highlights.* This is the most you pay during the calendar year for covered Medicare Part A and Part B services received 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 or your Employer or Union pay for the plan premiums 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 marked with an asterisk in the Medical Benefits Chart.) If you pay your in-network maximum out-of-pocket amount 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 or your Employer or Union must continue to pay our plan premium and the Medicare Part B premium (unless the Part B premium is paid by Medicaid or another third party).

Your **combined maximum out-of-pocket amount** is listed in your *Benefit Highlights.* This is the most you pay during the calendar year for covered Medicare Part A and Part B services received 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 or your Employer or Union pay for our plan premiums don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the

Medical Benefits Chart.) If you have paid your in-network maximum out-of-pocket amount 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 or your Employer or Union must continue to pay our plan premium and the Medicare Part B premium (unless the Part B premium is paid by Medicaid or another third party).

## Section 1.3 Our plan may have limits to 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 (described above), we also have a separate maximum out-of-pocket amount that may apply only to certain types of services.

Our plan has a maximum out-of-pocket amount for the following types of services:

The maximum out-of-pocket amount for in-network inpatient hospital care is listed in your *Benefit Highlights*. Once you've paid the maximum out-of-pocket amount for in-network inpatient hospital care, our plan will cover these services at no cost to you for the rest of the in-network inpatient hospital stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for in-network inpatient hospital care apply to your covered in-network inpatient hospital care. This means that once you've paid either the in-network maximum out-of-pocket amount for Part A and Part B medical services or the in-network maximum out-of-pocket amount for your in-network inpatient hospital care, our plan will cover your in-network inpatient hospital care at no cost to you for the rest of your in-network inpatient hospital stay.

The maximum out-of-pocket amount for in-network inpatient mental health care is listed in your *Benefit Highlights*. Once you've paid the maximum out-of-pocket amount for in-network inpatient mental health care, our plan will cover these services at no cost to you for the rest of the in-network inpatient mental health care stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for in-network inpatient mental health care apply to your covered in-network inpatient mental health care. This means that once you've paid either the in-network maximum out-of-pocket amount for Part A and Part B medical services or the in-network maximum out-of-pocket amount for your in-network inpatient mental health care, our plan will cover your in-network inpatient mental health care at no cost to you for the rest of your in-network inpatient mental health care stay.

## Section 1.4 Providers aren't allowed balance bill you

As a member of Personal Choice 65, 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), 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 the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- If you think a provider has balance billed you, call our Member Help Team at 1-888-879-4293 (TTY/TDD 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 Personal Choice 65 covers and what you pay out of pocket for each service. 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 may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- 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 by an asterisk 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 the 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 the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- 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, look in your Medicare & You 2026 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227).TTY 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.

Your *Benefit Highlights* is included as an insert with this document. If you can't find your *Benefit Highlights*, you can call the Member Help Team to have a new one sent to you.

 This apple shows preventive services in the Medical Benefits Chart.

**Medical Benefits Chart**

| Covered Service | What you pay |
|---|---|
| **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.<br>Risk factors for abdominal aortic aneurysm are:<br>• a family history of abdominal aortic aneurysms;<br>• a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime<br>You're considered at risk if you meet one of the criteria listed above. | **In network:**<br>There is no coinsurance or copayment for members eligible for this preventive screening.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **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 eight sessions will be covered for those 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:<br>• 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><br>(continued) | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Acupuncture for chronic low back pain (continued)**<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 are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. | **In network:**<br>* Prior authorization is required for non-emergency Medicare-covered ambulance.<br>**In or out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>Copayment may or may not be waived if admitted.<br>Some restrictions, including destination, may apply.<br>Please note: If you refuse transport when an ambulance is dispatched, the plan will not cover the cost of the ambulance and you will be responsible for the full cost of the service.<br>A round-trip for dialysis may require prior approval. |
| **Annual physical exam**<br>You may receive an annual physical examination. The annual physical examination includes a comprehensive review of systems and physical examination, including but not limited to the following: detailed family history, hands-on examination, general appearance, and EKG screening, heart, lung, head, and neck examinations. | **In network:**<br>There is no coinsurance or copayment for an annual physical exam.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Annual wellness visit**<br>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>**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.<br>Annual wellness visits are covered once a calendar year. | **In network:**<br>There is no coinsurance or copayment for the annual wellness visit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **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>There is no coinsurance or copayment for Medicare-covered bone mass measurement.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Breast cancer screening (mammograms)**<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>There is no coinsurance or copayment for covered screening mammograms.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.<br>If you receive a preventive test that turns into a diagnostic test or service during a procedure, there will be no copayment for the diagnostic test. |
| **Cardiac rehabilitation services**<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. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **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 or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **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 five years (60 months). | **In network:**<br>There is no coinsurance or copayment for cardiovascular disease testing that is covered once every five years.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **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 or copayment for Medicare-covered preventive Pap and pelvic exams.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **Chiropractic services**<br>Covered services include:<br>• Manual manipulation of the spine to correct subluxation<br>• Routine chiropractic care, up to six combined in-network and out-of-network supplemental visits per year<br>  ○ Six routine chiropractic visits include manual manipulation for maintenance chiropractic care. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>Routine chiropractic care information may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details.<br>* Cost sharing for routine chiropractic visits do not count toward your maximum out-of-pocket amount. |

| Covered Service | What you pay |
|---|---|
| **Chronic pain management and treatment services**<br><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.<br>**In network:**<br>There is no coinsurance or copayment for Chronic pain management and treatment services.<br>**Out of network:**<br>See your Benefit Highlights for cost-share amount. |

### Colorectal cancer screening

The following screening tests are covered:

- Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.
- Computed tomography colonography for patients 45 year and older who are not 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 was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening 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 the following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.
- Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for the 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.
- Screening fecal-occult blood test for patients 45 years and older. Once every 12 months.
- Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
- Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years.

**In network:**

There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam.

**Out of network:**

See your *Benefit Highlights* for cost-share amount.

**In or out of network:**

If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.

If you receive a preventive test that turns into a diagnostic test or service during a procedure, there will be no copayment for the diagnostic test.

| 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.<br>• Colorectal cancer screening tests include a plan screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. | |
| **Dental services**<br>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. | See your *Benefit Highlights* for cost-share amount for routine dental care.<br>Routine and Comprehensive dental services information may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details.<br>* Cost sharing for routine dental do not count toward your maximum out-of-pocket amount. |
| **Depression screening**<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. | **In network:**<br>There is no coinsurance or copayment for an annual depression screening visit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Diabetes screening**<br>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>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test. | **In network:**<br>There is no coinsurance or copayment for an annual diabetes screening visit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **Diabetes self-management training, diabetic services and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<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.<br>• For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.<br>(continued) | **In network:**<br>There is no coinsurance or copayment for the Medicare covered diabetes screening tests.<br>See your *Benefit Highlights* for cost-share amounts for:<br>• diabetic test strips and glucose monitors<br>• lancets and solutions<br>• custom-molded shoes and inserts<br>• insulin pumps and related supplies<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment or coinsurance will apply. The copayment or coinsurance amount depends on the provider type or place of service.<br>*Prior authorization is required for select diabetic supplies. |

| Covered Service | What you pay |
|---|---|
| **Diabetes self-management training, diabetic services and supplies (continued)**<br>• Diabetes self-management training is covered under certain conditions.<br>**Test strips and monitors must be obtained from preferred vendors Accu-Chek and Contour. Test strips and monitors from other vendors will not be covered.**<br>Lancets, solutions, insulin pumps and related supplies from any brand are available to members.<br>If Accu-Chek and Contour test strips do not work with your current monitor, please call your PCP to request a prescription for a replacement monitor.<br>Freestyle Libre is the only covered flash glucose monitoring device.<br>**Note:** Continuous glucose monitoring devices are covered under the durable medical equipment (DME) benefit. Please refer to the DME benefit chart in Chapter 4, Section 2.1. | **Out of network:**<br>See your *Benefit Highlights* for cost-share amounts for:<br>• diabetes self-management training preventive benefit<br>• diabetic test strips and glucose monitors<br>• lancets and solutions<br>• custom-molded shoes and inserts<br>• insulin pumps and related supplies<br>**In or out of network:**<br>For diabetic self-management training, if you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Durable medical equipment (DME) and related supplies**<br>(For a definition of durable medical equipment, go to Chapter 10 and as Chapter 3)<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>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 may ask them if they can special-order it for you. The most recent list of suppliers is available on our website at www.ibxmedicare.com. | **In network:**<br>* Prior authorization is required for certain items. For a list of DME that need precertification/prior authorization, please visit our website at www.ibxmedicare.com.<br>**In or out of network:**<br>See your *Benefit Highlights* for cost-share amount for Medicare-covered durable medical equipment.<br>See your *Benefit Highlights* for cost-share amount for Medicare-covered oxygen (liquid and gaseous oxygen) billed separately from the oxygen equipment.<br>See your *Benefit Highlights* for cost-share amount for Medicare oxygen equipment. |

| Covered Service | What you pay |
|---|---|
| **Emergency care**<br><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><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 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.<br><br>Emergency care is covered worldwide.<br><br>Worldwide ambulance services are not covered. | **In or out of network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>Copayment may or may not be waived if admitted to hospital<br><br>If you receive emergency care outside of the United States, you must pay for your care, and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 7, Section 5.5.<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 move to a network hospital to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.<br><br>* Cost sharing for emergency services received outside of the United States do not count toward your maximum out-of-pocket amount and are not waived if admitted. |

| Covered Service | What you pay |
|---|---|
| **Health and wellness education programs**<br>**Enhanced Disease Management:** Services are targeted to members with chronic health conditions. A case manager is assigned to a member following an acute admission. The case manager will focus on educating the member about the condition, medication review, and post-discharge planning. In addition, the case manager will teach the member to recognize early warning signs, and coordinate action with the treating physician if the condition deteriorates. The case manager's activities can include scheduling and tracking of physician appointments or in-home nursing visits, coordinating transportation needs, and installation and monitoring of telemonitoring equipment.<br>**Fitness Benefit:** Members receive a physical and mental fitness program through a plan-specific vendor with the goal of improving general health and well-being. The program includes:<br>• Access to a participating gym network<br>• On-demand and livestreamed digital content<br>• Home fitness kits include equipment such as resistance bands, yoga mats, and/or exercise tubes.<br>• Vendor-curated activities that are exercise driven to promote physical activity<br>• Access to complete brain workout, including an initial cognitive test and a brain training program focused on cognitive stimulation and neurological rehabilitation exercises.<br>Members must use a One Pass™ network gym/fitness center and enroll in the One Pass program.<br>Gym memberships and services received from non-One Pass fitness centers will be denied. | **In or out of network**:<br>There is no coinsurance or copayment for health and wellness education programs.<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Health and wellness education programs (continued)**<br>For more information, log in or register at www.youronepass.com or call 1-877-504-6830 (TTY/TDD: 711), Monday through Friday, from 9 a.m. to 10 p.m.<br>**Health Education:** Registered Nurse Health Coaches and Case Managers who are specialized Registered Nurses and Licensed Social Workers periodically assess each member's health care and provide outreach and guidance on a variety of topics. Registered Nurse Health Coaches and Case Managers seek to help members manage their conditions through monitoring, education, teaching self-care, and adopting healthy lifestyle changes.<br>**Nursing Hotline**: Members can call 1-800-ASK-BLUE (1-800-275-2583) (TTY/TDD: 711) 24 hours a day, 7 days a week. The hotline is staffed by nurses who will assist with questions and concerns about all health conditions and will provide support for managing chronic conditions. | |

| Covered Service | What you pay |
|---|---|
| **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 when you get them a physician, audiologist, or other qualified provider.<br>Non-Medicare-covered services include:<br>**Basic hearing evaluations and hearing aids must be provided by a TruHearing® provider.** All hearing services that are not covered by Medicare must be obtained by a TruHearing provider. Any care received from a non-participating provider will not be covered by the plan. To obtain routine hearing services, you must contact TruHearing at 1-855-541-6173 (TTY/TDD:711) Monday through Friday, 8 a.m. to 8 p.m. to schedule an appointment with a participating TruHearing provider.<br>• Routine hearing exams (not covered by Medicare), covered once every year<br>• Unlimited fitting and evaluation for hearing aid for the first yearUp to two TruHearing-branded hearing aids every year (one per ear, per year). This benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Both Advanced and Premium hearing aids are available in rechargeable style options. This benefit is combined in and out of network. You must see a TruHearing provider to use this benefit. Hearing aid services include:<br>o 60-day trial period<br>o 3-year extended warranty for loss or irreparable damage<br>o 80 batteries per aid for non-rechargeable models | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>Routine hearing services information may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details.<br>* Cost sharing for routine hearing services do not count toward your maximum out-of-pocket amount. |

(continued)

| Covered Service | What you pay |
|---|---|
| **Hearing services (continued)**<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 Additional batteries; batteries when a rechargeable hearing aid is purchased<br>o Hearing aids that are not TruHearing-branded hearing aids<br>o Costs associated with loss and damage warranty claims<br>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 who 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 three screening exams during a pregnancy | **In network:**<br>There's no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Home health agency care**<br><br>Before you 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><br>Covered services include, but aren't limited to:<br><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<br>• Medical equipment and supplies | **In network:**<br><br>There is no coinsurance or copayment for home health agency care.<br><br>* Prior authorization is required (includes home infusion therapy).<br><br>**Out of network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>**In or out of network:**<br><br>For a definition of "Homebound," see Chapter 10. |

| Covered Service | What you pay |
|---|---|
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<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>There is no coinsurance or copayment for home health agency care.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>* Prior authorization is required. |

| Covered Service | What you pay |
|---|---|
| **Hospice care**<br><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 our plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<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 chose to 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 are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.<br><br>(continued) | **In or out of network:**<br><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 prognosis are paid for by Original Medicare, not Personal Choice 65.<br><br>See your *Benefit Highlights* for cost-share amount for hospice consultation services.<br><br>For a definition of Respite Care, see Chapter 10. |

| Covered Service | What you pay |
|---|---|
| **Hospice care (continued)**<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).<br>• If you get the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services.<br>• If you get the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services.<br>**For services covered by Personal Choice 65 but not covered by Medicare Part A or B:** Personal Choice 65 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>**Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.<br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | |

| Covered Service | What you pay |
|---|---|
| **Immunizations**<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 vaccine if you are at high or intermediate risk of getting hepatitis B<br>• COVID-19 vaccines<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules | **In network:**<br>There is no coinsurance or copayment for the pneumonia, flu/influenza, hepatitis B, and COVID-19 vaccines.<br>**Out of network**:<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

**Inpatient hospital care**

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Unlimited days per admission. Covered services include but are not limited to:

- Unlimited medically necessary days per admission/stay
- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance use disorder services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.

**In network:**

See your *Benefit Highlights* for cost-share amount.

* Prior authorization is required.

**Out of network:**

See your *Benefit Highlights* for cost-share amount.

**In or out of network:**

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.

Copayment or coinsurance does not apply for the day of discharge.

(continued)

| Covered Service | What you pay |
|---|---|
| **Inpatient hospital care (continued)**<br>• 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 Personal Choice 65 provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.<br>• Blood — including storage and administration. All components of blood are covered beginning with the first pint used.<br>• Physician services<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>*Get more information Medicare fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hopsital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.* | |

| Covered Service | What you pay |
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| **Inpatient services in a psychiatric hospital**<br>Covered services include mental health care services that require a hospital stay.<br>• Unlimited days per admission in an acute care hospital<br>• 190-day lifetime benefit maximum for services in a freestanding psychiatric hospital | **In network:**<br>See your *Benefit Highlights* for cost-share amount.<br>* Prior authorization is required.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>Copayment or coinsurance does not apply for the day of discharge. |

| Covered Service | What you pay |
|---|---|
| **Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay**<br><br>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you receive while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:<br>• Physician services<br>• Diagnostic tests (like lab tests)<br>• X-ray, radium, and isotope therapy including technician materials and services<br>• Surgical dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• 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<br>• 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<br>• Physical therapy, speech therapy, and occupational therapy | **In or out of network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>There is no coinsurance or copayment for inpatient services covered during a non-covered inpatient stay. |

| Covered Service | What you pay |
|---|---|
| **Medical nutrition therapy**<br>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>We cover 3 hours of one-on-one counseling services during the first year you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | **In network:**<br>There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.<br>* Medical nutrition therapy requires a physician's order or prescription. |
| **Medicare Diabetes Prevention Program (MDPP)**<br>MDPP services are covered for eligible people under all Medicare health plans.<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. | **In network:**<br>There is no coinsurance or copayment for the MDPP benefit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

**Medicare Part B drugs**

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- The Alzheimer's drug, Leqembi ®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment
- Clotting factors you give yourself by injection if you have hemophilia
- Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at time you get immunosuppressive drugs.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) give them under appropriate supervision

  Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when

**In network:**

See your *Benefit Highlights* for cost-share amount.

Up to a $35 copayment for up to a one-month supply of insulin

Certain Part B Drugs may be subject to Step Therapy.

***** Prior authorization is required for certain Part B drugs. Please refer to the Precertification List at www.ibxmedicare.com/precert or contact our Member Help Team.

**Out of network:**

See your *Benefit Highlights* for cost-share amount.

| Covered Service | What you pay |
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| ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug.<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<br>• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B<br>• Calcimimetic 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, 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®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa<br>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>• Parenteral and enteral nutrition (intravenous and tube feeding)<br>The will take you to a list of Part B drugs that may be subject to Step Therapy: www.ibxmedicare.com/partbstep. We also cover some vaccines under our Part B drug benefit. | |

| Covered Service | What you pay |
|---|---|
| **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 or copayment for preventive obesity screening and therapy.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **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 or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Outpatient diagnostic tests and therapeutic services and supplies**<br><br>Covered services include, but aren't limited to:<br>• X-rays<br>• Radiation (radium and isotope) therapy including technician materials and supplies<br>• Surgical supplies, such as dressings<br>• Splints, casts and other devices used to reduce fractures and dislocations<br>• Laboratory tests<br>• Blood — including storage and administration. All components of blood are covered beginning with the first pint used<br>• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.<br>• Other outpatient diagnostic tests, e.g., ultrasounds and sleep studies (home or outpatient)<br><br>(continued) | **In network:**<br><br>*EKG Screening*<br><br>There is no coinsurance or copayment for EKG screening.<br><br>*Laboratory Tests*<br><br>There is no coinsurance or copayment for laboratory test.<br><br>Services must be performed at your PCP's designated site, with the exception of approved home sleep studies.<br><br>*Radiation Therapy, Complex Radiology (e.g., MRI/MRA, CT scans, nuclear cardiology studies), and Routine Radiology (e.g., X-ray, radiology, diagnostic services, ultrasounds)*<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>**Out of network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>**In or out of network:**<br><br>If services are performed at an ambulatory surgical center (ASC) or an outpatient hospital facility (OHF), your cost-sharing amount may differ.<br><br>Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply. |
| **Outpatient diagnostic tests and therapeutic services and supplies (continued)** | * Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.ibxmedicare.com. |

| Covered Service | What you pay |
|---|---|
| **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.<br>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<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 are not sure if you are an outpatient, you should ask the hospital staff.<br>If you aren't sure if you're an outpatient, ask the hospital staff. Get more information Medicare fact sheet *Medicare Hospital Benefits. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.* | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Outpatient hospital services**<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>Covered services include, but aren't limited to:<br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery<br>• Laboratory and diagnostic tests billed by the hospital<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>• X-rays and other radiology services billed by the hospital<br>• Medical supplies such as splints and casts<br>• 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 sure if you're an outpatient, ask the hospital staff.<br>(continued) | **In network:**<br>See your *Benefit Highlights* for cost-share amount for outpatient hospital services.<br>* Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization. Please visit our website at www.ibxmedicare.com<br>**In or out of network:**<br>See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information.<br>See Colorectal cancer screening for more information about:<br>Colorectal cancer screening<br>See Durable medical equipment and related supplies for more information about:<br>• Durable medical equipment<br>See Emergency care for more information about:<br>• Emergency room<br>See Medicare Part B prescription drugs for more information about:<br>• Part B drugs<br>See Outpatient mental health care or "Outpatient substance abuse services" for more information about:<br>• Mental health or substance abuse services<br>See Outpatient rehabilitation services for more information about:<br>• Rehabilitation therapy (physical, occupational, or speech therapy) |

| Covered Service | What you pay |
|---|---|
| **Outpatient hospital services (continued)** | See Outpatient diagnostic tests and therapeutic supplies and services for more information about:<br>• Complex radiology (MRI/MRA, CT scans, nuclear cardiology studies)<br>• EKG screening<br>• Laboratory tests<br>• Radiation therapy<br>• Routine radiology (X-ray, radiology, diagnostic services, ultrasounds)<br>See Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for more information about:<br>• Outpatient surgery<br>See Physician/Practitioner services, including doctor's office visits for more information about:<br>• Primary care provider<br>• Specialist<br>See Prosthetic devices and related supplies for more information about:<br>• Prosthetic devices<br>Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply.<br>For a definition of colorectal screening, see Chapter 10 of this document. |

| Covered Service | What you pay |
|---|---|
| **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.<br>If you receive partial hospitalization benefits, please see Partial hospitalization services for prior authorization restrictions. | **In network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In and out of network:**<br>* Prior authorization is required for certain services. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.ibxmedicare.com. |
| **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). | **In network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Outpatient substance use disorder services**<br>Personal Choice 65 provides outpatient services to help with conditions related to drug or alcohol abuse. Coverage includes care and treatment for alcohol or drug abuse provided by an acute hospital or mental health facility provider. Care and treatment includes, but is not limited to, the diagnosis and treatment of substance misuse, rehabilitation therapy, counseling and outpatient detoxification by a licensed behavioral health provider (such as a psychiatrist, clinical psychologist, nurse, or certified addiction counselor).<br>If you receive partial hospitalization benefits, please see "Partial hospitalization services" for prior authorization restrictions. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br><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. | **In network:**<br>See your *Benefit Highlights* for cost-share amount.<br>A copayment will not apply for a Preventive Colonoscopy that becomes diagnostic when received in an outpatient hospital or ASC.<br>* Prior authorization is required for certain items. For a list of covered medical services that need precertification/prior authorization, please visit our website at www.ibxmedicare.com.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam (Colorectal screening).<br>Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply.<br>For a definition of colorectal cancer screening, see Chapter 10 of this document. |

| Covered Service | What you pay |
|---|---|
| **Over-the-counter (OTC) items**<br>Your IBX Care Card can be used to purchase eligible over -the-counter (OTC) items in-store at participating retail locations. Eligible OTC items include first-aid supplies, vitamins, cold and allergy medicine, and more.<br>You can also use your IBX Care Card to place an order for eligible OTC items by phone or online via catalog for delivery through our dedicated vendor.<br>Non-eligible items or items purchased at non-participating retail locations will NOT be covered. Only our vendor/specified online retailer(s) may be used for online orders.<br>If a member exceeds the benefit amount, alternative payment will be required for the remaining balance due. Members should ask the provider of they accept split payment methods prior to receiving services<br>For additional details on the OTC benefit, including placing an order, participating retailers, and a list of eligible items, please visit www.ibxmedicare.com/carecard or contact our Member Help Team. | See your *Benefit Highlights* for cost-share amount.<br>The IBX Care Card OTC allowance is provided quarterly (every three months) and does not carry forward to the next quarter if it is not used.<br>Over-the-counter (OTC) items may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details. |

| Covered Service | What you pay |
|---|---|
| **Partial hospitalization services and Intensive outpatient services**<br><br>*Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that's more intense than the 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><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. | **In network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>* Prior authorization is required.<br><br>**Out of network:**<br><br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Physician/Practitioner services, including doctor's office visits**<br><br>Covered services include:<br>• Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>• Consultation, diagnosis, and treatment by a specialist<br>• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment<br>• Certain telehealth services, including PCP visits; specialist and other health care professional visits; and physical therapy, occupational therapy, and speech therapy visits.<br>  ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Please check with your health care provider for instructions on how to access their telehealth services, as well as any technology requirements (audio/video).<br>• 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<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location<br><br>(continued) | **In or out of network:**<br><br>*Primary Care Provider, Specialist, Other health care professional, Physical therapy/occupational therapy/speech therapy, and Mental health/substance abuse therapy services:*<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>Please check with your provider prior to scheduling services to see if the site is identified as part of a hospital, as the higher outpatient hospital facility copayment would apply.<br><br>**In network:**<br><br>*Mental health/substance abuse therapy services*<br><br>Must use an in-network behavioral health provider<br><br>**Out of network:**<br><br>Additional telehealth services for PCP visits, specialist visits, and physical therapy/occupational therapy/speech therapy received out of network will not be covered.<br><br>Telehealth for outpatient mental health care and outpatient substance abuse services are covered out of network. See the "Outpatient mental health care" and "Outpatient substance abuse services" for further detail. |

**Physician/Practitioner services, including doctor's office visits (continued)**

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

(continued)

| Covered Service | What you pay |
|---|---|
| **Physician/Practitioner services, including doctor's office visits (continued)**<br>• Consultation your doctor has with other doctors by phone, internet, or electronic health record<br>• Second opinion by another network provider prior to surgery | |
| **Podiatry services**<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 (Medicare-covered podiatry)<br>Routine foot care for members, up to six supplemental visits per year (non-Medicare-covered podiatry) | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>Routine foot care information may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details.<br>* Cost sharing for routine podiatry visits do not count toward your maximum out-of-pocket amount. |

| Covered Service | What you pay |
|---|---|
| **Pre-exposure prophylaxis (PrEP) for HIV prevention**<br>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.<br>If you qualify, covered services include:<br>• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.<br>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.<br>• Up to 8 HIV screenings every 12 months.<br>A one-time hepatitis B virus screening. | **In network:**<br>There is no coinsurance or copayment for the PrEP benefit.<br>**Out of network:**<br>See your Benefit Highlights for cost-share amount. |
| **Prostate cancer screening exams**<br>For men age 50 and older, covered services include the following – once every 12 months:<br>• Digital rectal exam<br>• Prostate Specific Antigen (PSA) test | **In network:**<br>There is no coinsurance or copayment for an annual PSA test.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Prosthetic and orthotic devices and related supplies**<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 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 section for more detail. | **In network:**<br>See your *Benefit Highlights* for cost-share amount.<br>* Prior authorization is required for certain services. For a list of covered medical services that need precertification/prior authorization\, please visit our website at www.ibxmedicare.com.required for certain items.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Pulmonary rehabilitation services**<br>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 or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |
| **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 or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>**Eligible members are**: people age 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who 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 or copayment for the Medicare-covered counseling and shared decision-making visit or for the LDCT.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.<br>* Prior authorization is required. |

| Covered Service | What you pay |
|---|---|
| **Screening for Hepatitis C Virus infection**<br>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:<br>• You're at high risk because you use or have used illicit injection drugs.<br>• You had a blood transfusion before 1992.<br>• You were born between 1945 – 1965.<br>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings. | **In network:**<br>There is no coinsurance or copayment for the Medicare-covered screening for the Hepatitis C Virus.<br>**Out of network:**<br>See your Benefit Highlights for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.<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 will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | **In network:**<br>There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **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 6sessions of kidney disease education services per lifetime<br>• 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)<br>• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)<br>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)<br>• Home dialysis equipment and supplies<br>• 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 about coverage for Part B Drugs, go to, **Medicare Part B drugs** in this table. | **In network:**<br>See your *Benefit Highlights* for cost-share amount for outpatient dialysis.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amounts for kidney disease education services, inpatient dialysis, and outpatient dialysis.<br>**In or out of network:**<br>*Inpatient dialysis*: No additional copayment or coinsurance for inpatient dialysis when received during an inpatient hospital stay.<br>*Kidney disease education services*: There is no coinsurance or copayment for kidney disease education services.<br>If performed at the provider's office, only dialysis coinsurance should apply. |

| Covered Service | What you pay |
|---|---|
| **Skilled nursing facility (SNF) care**<br><br>(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.)<br><br>100 days per Medicare benefit period. A prior hospital stay is not 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. All 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<br>• 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>(continued) | **In or out of network:**<br><br>A benefit period is the way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in an SNF) for 60 days in a row.<br><br>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.<br><br>**In network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>* Prior authorization is required.<br><br>**Out of network:**<br><br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Skilled nursing facility (SNF) care (continued)**<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 | |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>Smoking tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:<br>• 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>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive session, with the patient getting up to 8 sessions per year.) | **In network:**<br>There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.<br>**Out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>**In or out of network:**<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

| Covered Service | What you pay |
|---|---|
| **Supervised Exercise Therapy (SET)**<br>SET is covered for members who have symptomatic peripheral artery disease (PAD).<br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<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<br>• 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>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Telemedicine visits**<br><br>**Teladoc Health must be used for telemedicine visits.**<br><br>You have convenient and confidential access to quality board-certified, U.S.-licensed doctors for non-emergent general medical visits, mental/behavioral health visits, and dermatology consultations through Teladoc. Connect virtually from the comfort of your home via your computer, tablet, or smartphone. Additional telehealth services received from other in-network providers will include an in-office copay. Not all services can be provided as a telehealth visit. See the Physician/Practitioner services, including doctor's office visits section of the Medical Benefits Chart for more information on covered additional telehealth services.<br><br>**General medical visits**<br><br>24/7 access to talk to a doctor for non-emergency conditions like the flu, allergies, coughs, sore throats, rashes, and more.<br><br>Visits can be scheduled by calling 1-800-835-2362 (TTY/TDD: 711), online at teladochealth.com/signin, or via the Teladoc Health mobile app.<br><br>(continued) | ***General medical visits*** *(focused on non-emergent medical conditions by connecting to a state-licensed physician)*<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>***Mental/behavioral health visits*** *(focused on therapy and counseling services by connecting to a state-licensed therapist or psychiatrist)*<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>***Dermatology consultations*** *(focused on diagnosing and treating skin, hair, and nail conditions by connecting members to board-certified dermatologists)*<br><br>See your *Benefit Highlights* for cost-share amount. |

| Covered Service | What you pay |
|---|---|
| **Telemedicine visits (continued)**<br>**Mental/behavioral health visits**<br>Access to talk to a therapist or psychiatrist by appointment, 7 days a week from 7 a.m. to 9 p.m., by phone or video for depression, anxiety, stress, and more. You can choose to see the same provider for recurring visits.<br>Visits must be scheduled online at teladochealth.com/signin or by phone, or via the Teladoc Health mobile app.<br>Mental/behavioral health visits must be scheduled via the online platform www.teladochealth.com/signin orby phone. Members must complete a mental health assessment via the website platform or by phone prior to scheduling.<br>**Dermatology consultations**<br>Access to a dermatologist for diagnosing and treating skin conditions like eczema, psoriasis, acne, and more.<br>Dermatology consultations are not real-time visits. You can upload images via the secure online platform available 24/7 at teladochealth.com/signin, or via the Teladoc Health mobile app. You can ask follow-up questions via one message after the consultation for up to 7 days.<br>You may initiate more than 1 dermatology consultation at a time. You may consult with the same Dermatology provider each time.<br>*Teladoc Health is not available internationally.*<br>Members must complete a comprehensive medical history assessment either online or by telephone with a designated Teladoc Health representative, prior to receiving telemedicine services. | |

| Covered Service | What you pay |
|---|---|
| **Urgently needed services**<br>A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. 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. However, medically necessary routine providers (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.<br>Urgently needed services are covered worldwide.<br>For a list of network urgent care centers, please call our Member Help Team. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount.<br>If services are performed at a retail clinic, an urgent care center, or a worldwide urgent care center, your cost-sharing amount may differ.<br>For a definition of Retail Clinic, see Chapter 10 of this document.<br>If you receive urgent or emergency care outside of the United States, you must pay for your care, and submit the claim for reimbursement consideration. For details on submitting a reimbursement, see Chapter 7, Section 5.5.<br>Copayment may or may not be waived if admitted to inpatient hospital. |

| Covered Service | What you pay |
|---|---|
| **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 of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.<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.<br>• Our plan covers the Medicare-covered standard frames and lenses for cataracts up to the Medicare allowed amount.<br>• NOTE: Upgrades such as deluxe frames, progressive lenses, and additional lens upgrades (including but not limited to transition, scratch-resistant, or tinted lenses) are not covered for glasses/lenses after cataract surgery. You may pay for upgrades yourself if you choose. | **In or out of network:**<br>See your *Benefit Highlights* for cost-share amount for routine vision care.<br>There is no coinsurance or copayment for a Medicare-covered diabetic retinal eye exam or dilated retinal eye exam.<br>There is no coinsurance or copayment for Medicare-covered glaucoma screenings.<br>There is no coinsurance or copayment for one pair of Medicare-covered standard eyeglasses or contact lenses after each cataract surgery.<br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service.<br>Routine vision services information may not apply to your group plan. Please refer to your *Benefit Highlights* or speak with your benefit administrator for details.<br>Any cost-sharing for routine vision services do not count toward your maximum out-of-pocket amount.<br>* Cost sharing for non-Medicare-covered vision services do not count toward your maximum out-of-pocket amount. |

| Covered Service | What you pay |
|---|---|
| **Welcome to Medicare preventive visit**<br><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, and referrals for other care if needed.<br><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 would like to schedule your *Welcome to Medicare* preventive visit. | **In network:**<br><br>There is no coinsurance or copayment for the *Welcome to Medicare* preventive visit.<br><br>**Out of network:**<br><br>See your *Benefit Highlights* for cost-share amount.<br><br>**In or out of network:**<br><br>If you receive a separate additional non-preventive evaluation and/or service, a copayment will apply. The copayment amount depends on the provider type or place of service. |

## Section 2.1 Get care using our plan's national network

As a member of Personal Choice 65, you can visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO (MA PPO) network providers nationwide. By visiting any one of these participating MA PPO network providers, you will pay the in-network cost-sharing amount for your services.

Our plan has relationships with other Blue Cross and/or Blue Shield licensees (Host Blues) referred to generally as Blue Cross and/or Blue Shield Medicare Advantage PPO. When members access health care services, the claims for those services will be processed through the MA PPO Program and presented to our plan for payment in accordance with the rules of the MA PPO Program policies.

When seeking care, if there are no MA PPO network providers in your area, you may visit any Medicare-eligible provider and receive coverage at the highest benefit level.

To obtain additional information about this plan benefit, you may:

- Call our Member Help Team;
- Call 1-800-810-BLUE to find out what providers you may visit when out of state;
- Visit the "Doctor Hospital Finder" at www.BCBS.com to find a participating provider.

**Nonparticipating Health Care Providers Outside Our Service Area**

When covered services are provided outside of our service area by nonparticipating health care providers, the amount(s) a member pays for such services will be based on either the payment arrangements, described above, for Medicare Advantage PPO network providers, Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

## 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 7, Section 5.3.)

| **Services not covered by Medicare** | **Covered only under specific conditions** |
|---|---|
| **Acupuncture** | Available for people with chronic low back pain under certain circumstances.<br><br>Routine non-Medicare-covered services:<br><br>Covered for headache (migraine and tension), postoperative nausea and vomiting, chemotherapy-induced nausea and vomiting, low back pain, chronic neck pain, pain from osteoarthritis of the knee and hip |
| **Cosmetic surgery or procedures** | Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.<br><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><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 |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **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 |
| **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.<br>Routine and Comprehensive Dental may or may not be covered, see your dental benefit highlights. |
| **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. |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **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** | Not covered under any condition Covered only when medically necessary |
| **Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids** | One pair of eyeglasses (or one set of contact lenses) are covered after each cataract surgery that implants an intraocular lens.<br>Routine eye exams and eyewear may or may not be covered, see your vision benefit highlights. |
| **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>Routine supplemental visits, up to six per year, may or may not be covered, see your benefit highlights. |
| **Routine foot care** | Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).<br>Routine supplemental visits, up to six per year, may or may not be covered, see your benefits highlights. |
| **Services considered not reasonable and necessary, according to Original Medicare standards** | Not covered under any condition |
| **Worldwide ambulance services** | Not covered under any condition |

# CHAPTER 5:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When you send us a request for payment, we'll review your request and decide whether the service 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 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you 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 12 months** of the date you got the service or item.

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.ibxmedicare.com) or call our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711) and ask for the form.

Whether you choose to use the form or not, the following information is needed in order for us to identify you and process your request for payment:

- Member name
- Member ID number (located on your member ID card)
- Member date of birth
- Date of service
- Procedure code (located on the bill or receipt from the provider)
- Diagnosis code (located on the bill or receipt from the provider)
- Billed charges/amounts

- Provider name and National Provider Identifier (NPI)
- Receipt or proof of payment

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

For medical payment requests (Part C):

Independence Blue Cross
Claims Receipt Center
PO Box 211184
Eagan, MN 55121

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

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

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

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

# CHAPTER 6:

*Your rights and responsibilities*

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

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

We may request demographic information from you, such as race, ethnicity, language sexual orientation, and gender identity. We may also request information about social needs essential to your well-being. Sharing this information with us helps us better understand and meet the diverse needs of our members. Your response to our request for demographic information is optional.

Our plan has free interpreter services available to answer questions from non-English-speaking members. We can also give you materials in braille, in data CD, in large print, or in audio 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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 is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with our Member Help Team at 1-888-879-4293. (TTY/TDD users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY: 1-800-537-7697.

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

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 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. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711).

IBX is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

The *Notice of Privacy Practices* describes how IBX may use and disclose a member's personal health information and how a member of an IBX health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit www.ibxmedicare.com/privacy. You can also call to request a copy of the *Notice of Privacy Practices* by contacting our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711).

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

As a member of Personal Choice 65, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711):

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

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

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

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

- **To know about all your choices**. You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **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. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

### You have the right to give instructions about what'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 your 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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 have 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.

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

**What if your instructions are not 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 Pennsylvania Department of Health. Call the Complaint Hotline at 1-800-254-5164 or use the online form at apps.health.pa.gov/dohforms/FacilityComplaint.aspx.

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

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

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

You've the right to be treated with fairness, respect, and recognition of your dignity. 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 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 our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711).**
- **Call your local SHIP** at 1-800-783-7067
- **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 our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711)**
- **Call your local SHIP** at 1-800-783-7067
- **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).

You also have the right to make recommendations regarding our rights and responsibilities policy by calling our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711).

## 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, 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 your medical care.
- **Help your doctors, other providers, and IBX help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors, other health providers, and IBX about your health problems. Participate in developing mutually agreed-upon treatment goals, to the degree possible. 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 premium for your Medicare Part B to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- If you move, tell Social Security (or the Railroad Retirement Board).

# SECTION 3 Member communications

## Section 3.1 Member connections

There are many ways that you can connect with our plan and manage your health care coverage, whether on paper or online.

**Health Needs Assessment**

You may receive a health risk assessment survey that helps us learn more about your health care needs. The information provided will not affect your enrollment in the plan or your premium.

**Personal Health Visit**

Personal health visits are a convenient way to get personalized health assessment and advice in the comfort of your home and are offered to you **at no extra cost**. This service is optional, does not affect your current health insurance benefits or premiums, and does not replace your annual wellness visit.

**Member Site**

Log in or register at www.ibx.com/login, anytime and anywhere to find all your health and benefit information in one place. Access your member ID card, the *Provider/Pharmacy* Finder, the status of recent claims, and important messages. You can also visit our website at www.ibxmedicare.com for plan documents, health and wellness information, and more.

**Find a Doctor or Hospital:** Our online *Find a Provider* tool helps you find an in-network provider. You can search for medical providers and facilities within the tool at www.ibxmedicare.com/providerfinder. The information about network providers available on the *Find a Provider* tool includes:

- Name, address, and telephone numbers
- Professional qualifications

- Specialty
- Medical school attended
- Residency completion
- Board certification status
- Language spoken, gender, race, and/or ethnicity

**Medical Technology Assessment**

Our plan uses the technology assessment process to assure that new drugs, procedures, or devices are safe and effective before approving them as a covered service. When new technology becomes available, or, at the request of a practitioner or member, the plan researches all scientific information available from these expert sources. Following this analysis, the plan:

- Decides about when a new drugs, medical procedures, behavioral health procedures or device has been proven to be safe and effective; and
- Uses this information to determine when an item becomes a covered service.

The review and evaluation of available clinical and scientific information is done by expert sources. These sources include, but are not limited to:

- Publications from government agencies;
- Peer-reviewed journals;
- Professional guidelines;
- Regional and national experts;
- Clinical trials; and
- Manufacturers' literature.

## Section 3.2 Utilization management reviews

The professional providers, independent medical consultants, medical directors, or nurses that perform utilization review services are not compensated or given incentives based on coverage review decisions. Medical directors and nurses are salaried and contracted external physicians and other professional consultants are compensated on a per case-reviewed basis, regardless of the coverage determination. The health benefit plan does not specifically reward or provide financial incentives for issuing denials of coverage. There are no financial incentives for such individuals, which would encourage utilization review decisions that result in underutilization.

# CHAPTER 7:

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

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

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

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

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

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

## Section 1.1 Legal terms

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

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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) (TTY users should 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're covered, and problems related to payment for medical care.

**Yes.**

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

**No.**

Go to **Section 9**, **How to make a complaint about quality of care, waiting times, customer service 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 a 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 that 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.

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 when asking for a coverage decision or making an appeal

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

- **Call us at our Member Help Team at 1-888-879-4923 (TTY/TDD 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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.pdfor on our website at www.ibxmedicare.com.)
  - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or another person to be your representative, call our Member Help Team at 1-888-879-4923 (TTY/TDD 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.pdfor on our website at www.ibxmedicare.com.) 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 begin or 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 your different situations

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

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7**: 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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 ask 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 that this care 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 being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

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

## Section 5.2 How to ask for a coverage decision

**Legal Terms:**

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

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

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

**A standard coverage decision is usually made within 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 care 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 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 9 of this chapter 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 days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 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 of this chapter.

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

**If you're asking for a standard appeal, submit your standard appeal in writing.** 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 send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

***Deadlines for a standard appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get, 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 9 of this chapter for more 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 of the information related to your appeal.

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for standard requests. For expedited requests, we have 72 hours from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. **For expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal.)** In this case, the independent review organization will send you a letter:
  - Explains the decision.
  - 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 8 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 5 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 coverage 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 the cost typically within 30 calendar days but not 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 have already received and paid for, you aren't allowed to ask for a fast appeal.

- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

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

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

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

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

### Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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 the 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'll 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 our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

To ask us to cover 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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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's right (medically appropriate) for you to be discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling our Member Help Team at 1-888-879-4923 (TTY/TDD 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 do so if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital and we 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's right (medically appropriate) for you to be discharged on that date.

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

***What happens if the answer is yes?***

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

***What happens if the answer is no?***

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

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

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

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

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

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

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

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

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

**Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you 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's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

***If the independent review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal.
- 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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

### Legal Term:

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

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

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

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 our Member Help Team at 1-888-879-4923 (TTY/TDD 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 who are paid by the federal government to check on and 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 may do so 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 services 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, then **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 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

***What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you have 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 the details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

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

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

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

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

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you receive 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 at 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 on to a Level 5 appeal and how to continue with a Level 5 appeal.

### Level 5 appeal

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

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

## Making Complaints

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

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

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

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you got (including care in the hospital)? |
| **Respecting your privacy** | • Did someone not respect your right to privacy or 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 Help Team?<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 Help Team or other staff at our plan?<br>  ○ 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** (These types of complaints are all about the timeliness of our actions related to coverage decisions and appeals) | If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:<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 9.2 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**.

### 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 our Member Help Team at 1-888-879-4923 (TTY/TDD users call 711) is usually the first step.** If there's anything else you need to do, our Member Help Team will let you know.

**If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.

**Here is our formal procedure for answering grievances:**

- Standard Grievance Process

  If we can't resolve your issue over the phone, we have a formal procedure to review your issues. To use the formal grievance procedure, please call 1-888-879-4293 (TTY/TDD: 711) 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to Personal Choice 65 Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652. You will receive notification of the resolution of your grievance.

- Expedited (Fast) Grievance Process

  As a member, you may file an expedited grievance with our plan for the following reasons only:
- We decided to invoke an extension to, or reconsidered the time frames for, an organization determination; and/or

- We refused to grant your request for an expedited organization determination or reconsideration, or coverage determination or redetermination.

  We only respond within 24 hours of receiving your expedited grievance request if it for a valid reason. To file an expedited grievance, please call 1-888-879-4293 (TTY/TDD: 711), 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, mail a written request to Personal Choice 65 Medicare Member Appeals Unit, PO Box 13652, Philadelphia, PA 19101-3652.

You can also submit your complaint to us by fax (see Chapter 2 for more information).

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

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

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

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

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

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

*Or*

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

## Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Personal Choice 65 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 can call 1-877-486-2048.

# CHAPTER 8:

*Ending membership in our plan*

# SECTION 1 Ending your membership in our plan

Ending your membership in Personal Choice 65 (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 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.
  - Original Medicare *without* a separate Medicare drug plan.
- Your membership will end in our plan when your new plan's coverage starts on January 1.

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

You can make *one* change to your health coverage during the **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 enrollees 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 Personal Choice 65 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 we violate our contract with you.
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **Enrollment time periods vary** depending on your situation.
- **To find out if you're eligible for a Special Enrollment Period**, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY 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.

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

## Section 2.4 Get more information about when you can end your membership

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

- **Call our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711)**.
- Find the information in the ***Medicare & You 2026*** handbook.
- Contact **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 Personal Choice 65 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 Personal Choice 65 when your new plan's coverage starts. |
| **Original Medicare *without* a separate Medicare drug plan.** | • **Send us a written request to disenroll.** Contact our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711) if you need more information on how to do this.<br>• You can also contact **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 Personal Choice 65 when your coverage in Original Medicare starts. |

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

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

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

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

## SECTION 5 Personal Choice 65 must end our plan membership in certain situations

**Personal Choice 65 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 our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711) to find out if the place you're moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you 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 have questions or want more information on when we can end your membership, call our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711).

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

Personal Choice 65 (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, you should 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 9:

*Legal notices*

## SECTION 1 Notice about governing law

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

## SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY: 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 our Member Help Team at 1-888-879-4293 (TTY/TDD users call 711). If you have a complaint, such as a problem with wheelchair access, our Member Help Team 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, Personal Choice 65, 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 Notice about reporting fraud, waste, and abuse

Health care fraud, waste, and abuse are violations of state and/or Federal law. The Independence Blue Cross Corporate and Financial Investigations Department helps to protect members and providers from fraudulent and abusive practices. If you know of or suspect health insurance fraud, waste, or abuse, please report it. You are not required to provide identifying information about yourself when reporting fraud, waste, and abuse. Call the toll-free Fraud Hotline at 1-866-282-2707.

## SECTION 5 Additional information about Medicare Secondary Payer subrogation rights

Personal Choice 65 is subrogated to all your rights against any party legally liable to pay for your injury, illness, or medical expenses. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, liability insurance, umbrella insurance, or any other form or type of insurance. Personal Choice 65 may assert this right independently of you. However, Personal Choice 65 is not obligated in any way to pursue this right independently or on behalf of you but may choose to pursue its rights to reimbursement from you under the plan, at its sole discretion. Personal Choice 65 subrogation/reimbursement right is the first priority, and the full amount of medical expenses that were paid by Personal Choice 65 must be repaid in full before funds are allotted toward any other form of damages, regardless of whether you are fully compensated for other damages.

In cases of occupational illness or injury, Personal Choice 65's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include Personal Choice 65's interest and Personal Choice 65 shall be reimbursed in first priority from any such award or settlement.

You or anyone acting legally on your behalf must:

- Fully cooperate with Personal Choice 65 to protect Personal Choice 65's subrogation/reimbursement rights;
- Give notice of Personal Choice 65's claim to third parties and their insurers who may be legally responsible;
- Provide Personal Choice 65 with relevant information, and sign and deliver such documents as Personal Choice 65 reasonably request to secure Personal Choice 65's subrogation/reimbursement claim;
- Request Personal Choice 65's consent before releasing any party from liability for medical expenses or services paid or provided and;
- Fully reimburse Personal Choice 65 or its designated representative immediately upon receiving compensation from a third party, regardless of how the compensation is described or designated.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, Personal Choice 65's subrogation/reimbursement rights. In other words, you must not do anything or take any steps to jeopardize the recovery rights of Personal Choice 65.

## SECTION 6 Notice of Privacy Practices

IBX is committed to protecting the privacy of our members' personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures. The Notice of Privacy Practices describes how IBX may use and disclose a member's personal health information and how a member of an IBX health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit

www.ibxmedicare.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting our Member Help Team.

# CHAPTER 10:

*Definitions*

**Allowed Amount** – The allowed amount is the maximum amount a plan will pay for a covered health care service. If your provider charges more than our plan's allowed amount, you may have to pay the difference.

**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 payment for services 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 Personal Choice 65, 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. Our plan uses benefit periods for skilled nursing facility stays, but we do not use benefit periods to measure inpatient hospital stays. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in an 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's no limit to the number of benefit periods.

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

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

**Colorectal screening** – A series of cancer screening tests to help find precancerous growths or find cancer early when treatment is most effective.

**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 1.2 for information about your combined maximum out-of-pocket amount.

**Complaint** – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about 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. A copayment is a set amount (for example $10), rather than a percentage.

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

**Covered Services** – The term we use 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.

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

**Diagnostic Colonoscopy** – If a colorectal screening test results in the biopsy or removal of a lesion or growth during the same visit, according to Medicare, the procedure is now considered diagnostic. There will be no copayment for that diagnostic test.

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

**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.

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

**Grievance** - A type of complaint you make about our plan or providers, 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).

**Home Setting –** A location at which you primarily reside and receive certain health care services. Health care provided in a home setting can include care given by skilled medical professionals, including skilled nursing care, physical therapy, occupational therapy, and speech therapy. Custodial care, as defined in this document, can also be received in a home setting. Medicare does not cover custodial care provided in a home health care setting.

**Homebound** – Leaving your home is not recommended because of your condition; or, your condition keeps you from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or, leaving home takes a considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

**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've 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.

**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 three months before the month you turn 65, includes the month you turn 65, and ends three 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.

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

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

**Medically Necessary** – Services, 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**. Personal Choice 65 does not offer Medicare prescription drug coverage.

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

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

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

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

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

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

**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 Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan like 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 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 gotten is also referred to as the member's *out-of-pocket* cost requirement.

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

**Palliative Care** –Care for adults with serious illness that focuses on relieving suffering and improving quality of life for patients and their families but is not intended to cure the disease itself.

**Part C –** Go to Medicare Advantage (MA) Plan.

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Per Year** – Refers to the period in which you have health care coverage and can obtain services covered under your plan. This period is between January 1, 2026, and December 31, 2026. This is also known as the "plan year," "contract year," "benefit year," or "coverage year."

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

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

**Preventive 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 covered services based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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

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

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

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

**Respite Care** – A temporary institutional care of a dependent elderly, ill, or handicapped person, which provides relief for their usual caregivers.

**Retail Clinic** – A type of walk-in clinic located in a supermarket, pharmacy, or retail store where members can receive preventive care or treatment for uncomplicated minor illnesses in a nonemergency setting.

**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 plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

routine provider visits (like annual checkups)aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

**Website URL** – The address of a resource (such as a document or website) on the Internet. URL stands for "uniform resource locator" or a "universal resource locator."

## Personal Choice 65 Member Help Team

| | Member Help Team – Contact Information |
|---|---|
| **Call** | 1-888-879-4293<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail.<br>Our Member Help Team 1-888-879-4293 (TTY/TDD users call 711) also has free language interpreter services available for non-English speakers. |
| **TTY/TDD** | 711<br>Calls to this number are free. Same hours as the phone number above. |
| **Fax** | 1-888-289-3029<br>215-238-7960 |
| **Write** | Personal Choice 65<br>PO Box 7799<br>Philadelphia, PA 19101-7799 |
| **Website** | www.ibxmedicare.com |

## PA MEDI (Pennsylvania's SHIP)

PA MEDI is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

| | Contact Information |
|---|---|
| **Call** | 1-800-783-7067 |
| **Write** | PA MEDI<br>Commonwealth of Pennsylvania Department of Aging<br>555 Walnut Street, 5th Floor<br>Harrisburg, PA 17101-1919 |
| **Website** | www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx |

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