Evidence of coverage 2022

TRS-Care Medicare Advantage plan

UnitedHealthcare® Group Medicare Advantage (PPO)
TRS-Care Medicare Advantage
Group Number: 15725

Toll-free **1-866-347-9507,** TTY **711**
7 a.m. - 6 p.m. CT, Monday - Friday

www.UHCRetiree.com/TRS-CareMA

United Healthcare®

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January 1, 2022 - December 31, 2022

Evidence of coverage

Your Medicare Health Benefits and Services as a Member of our plan

This booklet gives you the details about your Medicare health care coverage from January 1, 2022 - December 31, 2022. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

This plan, TRS-Care Medicare Advantage, is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means TRS-Care Medicare Advantage.)

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-866-347-9507 for additional information (TTY users should call 711). Hours are 7 a.m. - 6 p.m. CT, Monday - Friday.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, cartas en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-866-347-9507, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 7 a.m. a 6 p.m., hora del Centro, de lunes a viernes.

Benefits, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

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

2022 Evidence of coverage
Table of contents

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

Chapter 1

Getting started as a member

Chapter 1
Getting started as a member

Section 1 Introduction

Section 1.1 You are enrolled in TRS-Care Medicare Advantage, which is a Medicare PPO Plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, TRS-Care Medicare Advantage.

There are different types of Medicare health plans. Our plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). The TRS-Care Medicare Advantage plan does not include Part D prescription drug coverage. Your prescription drug coverage is administered separately by SilverScript. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

When the contract for Medicare Advantage is purchased by TRS to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of the plan.

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

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

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

This **Evidence of Coverage** is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form or your verbal or electronic election of our

plan, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in the plan between January 1, 2022 and December 31, 2022.

Each plan year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the plan after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- **– and –** you live in our geographic service area (Section 2.3 below describes our service area).
- **– and –** you are a United States citizen or are lawfully present in the United States

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

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

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

If you are not entitled to Medicare Part A, please refer to your TRS-Care Medicare Advantage enrollment materials, or contact TRS directly to determine if you are eligible to enroll in our plan. Some plan sponsors have made arrangements with us to offer a Medicare Advantage plan even though you aren't entitled to Part A based on former employment.

Section 2.3 Here is the plan service area for TRS-Care Medicare Advantage

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes the 50 United States and the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the cover of this booklet) **and TRS Health & Insurance Benefits Department** at 1-888-237-6762 (TTY: 711), 7 a.m. – 6 p.m., CT Monday – Friday.

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

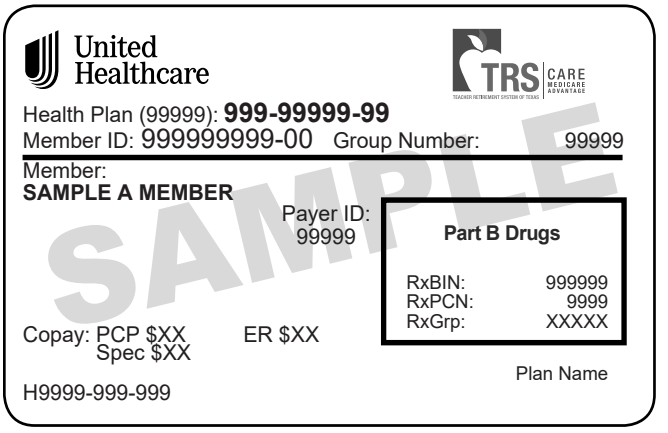
Section 2.4 U.S. Citizen or Lawful Presence

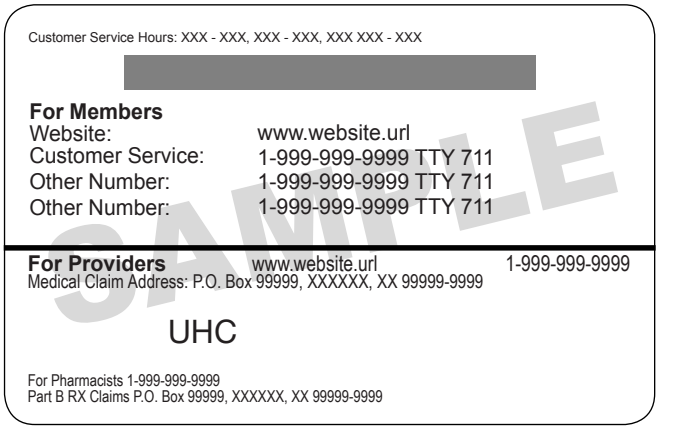
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify TRS if you are not eligible to remain a member on this basis. TRS must disenroll you if you do not meet this requirement.

Section 3 What other materials will you get from us?

Section 3.1 Your TRS-Care Medicare Advantage member ID card – Use it to get all covered care

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





Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your TRS-Care Medicare Advantage member ID 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 routine research studies. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by the plan or by Medicare.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your TRS-Care Medicare Advantage member ID card while you are a plan member, you may have to pay the full cost yourself.

If your TRS-Care Medicare Advantage member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the cover of this booklet.)

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

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.UHCRetiree.com/TRS-CareMA.

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

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the provider accepts Medicare and is willing to bill UnitedHealthcare, and the services are covered benefits and medically necessary. See Chapter 3 **(Using the plan's coverage for your medical services)** for more specific information.

If you don't have your copy of the **Provider Directory**, you can request a copy from Customer Service (phone numbers are printed on the cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also search for provider information on our website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers. (You can find our website and phone information on the cover of this booklet.)

Section 4 Your monthly premium for the plan

Section 4.1 How much is your plan premium?

You pay your TRS-Care Medicare Advantage PPO premiums directly to TRS. You can find monthly premiums here: https://www.trs.texas.gov/TRS%20Documents/trs-care_plan_highlights_2022.pdf. In addition to paying the monthly premium to TRS, you may pay a premium for Medicare Part A, which is free for some people. However, TRS-Care participants are not required to purchase Medicare Part A if they're not eligible to get it for free. Most people will also pay a premium for

Medicare Part B. You must pay all premiums to remain a member of TRS-Care Medicare Advantage PPO.

Many members are required to pay other Medicare premiums

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

Your copy of the **Medicare & You 2022** handbook gives information about these premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of the **Medicare & You 2022** handbook each year in the fall from the Centers for Medicare & Medicaid Services (CMS). Those new to Medicare receive it within a month after first signing up. You can also download a copy of the **Medicare & You 2022** handbook from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year TRS will notify you.

Section 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, Workers' Compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

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

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

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

Section 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

Section 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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

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

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

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

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

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

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

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

Chapter 2

Important phone numbers and resources

Chapter 2
Important phone numbers and resources

Section 1 TRS-Care Medicare Advantage Contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or TRS-Care Medicare Advantage member ID card questions, please call or write to our plan Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
Call	**1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
Write	UnitedHealthcare Customer Service Department P.O. Box 30769, Salt Lake City, UT 84130-0769
Website	**www.UHCRetiree.com/TRS-CareMA**

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

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

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

Method	Coverage Decisions for Medical Care – Contact Information
Call	**1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday

Method	Coverage Decisions for Medical Care – Contact Information
Write	UnitedHealthcare P.O. Box 30769, Salt Lake City, UT 84130-0769
Website	**www.UHCRetiree.com/TRS-CareMA**

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

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

Method	Appeals for Medical Care – Contact Information
Call	**1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday For fast/expedited appeals for medical care: **1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
Fax	**1-844-226-0356**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6103, MS CA124-0157, Cypress, CA 90630-0023
Website	**www.UHCRetiree.com/TRS-CareMA**

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

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

Method	Complaints about Medical Care – Contact Information
Call	**1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday For fast/expedited complaints about medical care: **1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
Fax	**1-844-226-0356**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6103, MS CA124-0157, Cypress, CA 90630-0023
Medicare Website	You can submit a complaint about TRS-Care Medicare Advantage directly to Medicare. To submit an online complaint to Medicare go to **www.medicare.gov/MedicareComplaintForm/home.aspx.**

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

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

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

Method	Payment Requests – Contact Information
Call	**1-866-347-9507** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday
TTY	**711** Calls to this number are free. Hours of Operation: 7 a.m. - 6 p.m. CT, Monday - Friday

Method	Payment Requests – Contact Information
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 30995, Salt Lake City, UT 84130-0995
Website	**www.UHCRetiree.com/TRS-CareMA**

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

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

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

Method	Medicare – Contact Information
Call	**1-800-MEDICARE,** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: □ **Medicare Eligibility Tool:** Provides Medicare eligibility status information. □ **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area.

Method	Medicare – Contact Information
	Because your coverage is provided by TRS, you will not find TRS-Care Medicare Advantage plans listed on www.medicare.gov. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about TRS-Care Medicare Advantage: □ **Tell Medicare about your complaint:** You can submit a complaint about TRS-Care Medicare Advantage directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.).

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- Alaska - Alaska Medicare Information Office
- Alabama - Alabama State Health Insurance Assistance Program (SHIP)
- Arkansas - Arkansas Senior Health Insurance Information Program (SHIIP)
- American Samoa - American Samoa Senior Health Insurance Program
- Arizona - Arizona State Health Insurance Assistance Program
- California - California Health Insurance Counseling & Advocacy Program (HICAP)
- Colorado - Colorado Senior Health Insurance Assistance Program (SHIP)
- Connecticut - Connecticut CHOICES Senior Health Insurance Program
- District of Columbia - Department of Aging and Community Living
- Delaware - Delaware Medicare Assistance Bureau (DMAB)
- Florida - Florida Serving Health Insurance Needs of Elders (SHINE)
- Georgia - GeorgiaCares Senior Health Insurance Plan
- Guam - Guam Medicare Assistance Program (GUAM MAP)
- Hawaii - Hawaii SHIP
- Iowa - Iowa Senior Health Insurance Information Program (SHIIP)

- Idaho - Idaho Senior Health Insurance Benefits Advisors (SHIBA)
- Illinois - Illinois Senior Health Insurance Program (SHIP)
- Indiana - Indiana State Health Insurance Assistance Program (SHIP)
- Kansas - Kansas Senior Health Insurance Counseling for Kansas (SHICK)
- Kentucky - Kentucky State Health Insurance Assistance Program (SHIP)
- Louisiana - Louisiana Senior Health Insurance Information Program (SHIIP)
- Massachusetts - Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
- Maryland - Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP)
- Maine - Maine State Health Insurance Assistance Program (SHIP)
- Michigan - Michigan MMAP, Inc. Senior Health Insurance Program
- Minnesota - Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
- Missouri - Missouri CLAIM Senior Health Insurance Program
- Northern Mariana Islands - North Mariana Islands Senior Health Insurance Program
- Mississippi - Mississippi Department of Human Services, Division of Aging & Adult Services
- Montana - Montana State Health Insurance Assistance Program (SHIP)
- North Carolina - North Carolina Seniors Health Insurance Information Program (SHIIP)
- North Dakota - North Dakota Senior Health Insurance Counseling (SHIC)
- Nebraska - Nebraska Senior Health Insurance Information Program (SHIIP)
- New Hampshire - New Hampshire SHIP - ServiceLink Aging and Disability Resource Center
- New Jersey - New Jersey State Health Insurance Assistance Program (SHIP)
- New Mexico - New Mexico Benefits Counseling Program SHIP
- Nevada - Nevada State Health Insurance Assistance Program (SHIP)
- New York - New York Health Insurance Information Counseling and Assistance Program (HIICAP)
- Ohio - Ohio Senior Health Insurance Information Program (OSHIIP)
- Oklahoma - Oklahoma Medicare Assistance Program (MAP)
- Oregon - Oregon Senior Health Insurance Benefits Assistance (SHIBA)
- Pennsylvania - Pennsylvania Senior Health Insurance Program
- Puerto Rico - Puerto Rico State Health Insurance Assistance Program (SHIP)
- Rhode Island - Rhode Island State Health Insurance Assistance Program (SHIP)
- South Carolina - South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders
- South Dakota - South Dakota Senior Health Information & Insurance Education (SHIINE)
- Tennessee - Tennessee Commission on Aging & Disability - TN SHIP
- Texas - Texas Department of Aging and Disability Services (HICAP)
- Utah - Utah Senior Health Insurance Information Program (SHIP)
- Virginia - Virginia Insurance Counseling and Assistance Program (VICAP)
- Virgin Islands of the U.S. - Virgin Islands State Health Insurance Assistance Program (VISHIP)
- Vermont - Vermont State Health Insurance Assistance Program (SHIP)
- Washington - Washington Statewide Health Insurance Benefits Advisors (SHIBA)
- Wisconsin - Wisconsin State Health Insurance Plan (SHIP)
- West Virginia - West Virginia State Health Insurance Assistance Program (WV SHIP)
- Wyoming - Wyoming State Health Insurance Information Program (WSHIIP)

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

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

Method to access SHIP and other resources
☐ Visit www.medicare.gov ☐ Click on **"Forms, Help, and Resources"** on far right of menu on top ☐ In the drop down click on **"Phone Numbers & Websites"** ☐ You now have several options o Option #1: You can have a **live chat** o Option #2: You can click on any of the **"TOPICS"** in the menu on bottom o Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Alaska | Alaska Medicare Information Office 550 W 7th Ave, STE1230 Anchorage, AK 99501 http://dhss.alaska.gov/dsds/Pages/medicare	1-800-478-6065 TTY 1-800-770-8973
Alabama | Alabama State Health Insurance Assistance Program (SHIP) 201 Monroe ST, STE 350 Montgomery, AL 36104 www.AlabamaAgeline.gov	1-877-425-2243 TTY 711
Arkansas | Arkansas Senior Health Insurance Information Program (SHIIP) 1 Commerce Way Little Rock, AR 72202 www.shiipar.com/landing-page	1-800-224-6330 TTY 711
American Samoa | American Samoa Senior Health Insurance Program ASTCA Executive BLDG #306, P.O. Box 6101 Pago Pago, AS 96799 www.medicaid.as.gov	1-684-699-4777 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Arizona | Arizona State Health Insurance Assistance Program 1366 E Thomas RD, STE 108 ATTN: SHIP Phoenix, AZ 85104 https://des.az.gov/services/older-adults/medicare-assistance	1-800-432-4040 TTY 711
California | California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National DR, STE 200 Sacramento, CA 95834-1992 http://www.aging.ca.gov/hicap/	1-800-434-0222 TTY 1-800-735-2929
Colorado | Colorado Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, STE 850 Denver, CO 80202 https://www.colorado.gov/pacific/dora/senior-healthcare-medicare	1-888-696-7213 TTY 711
Connecticut | Connecticut CHOICES Senior Health Insurance Program 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns	1-800-994-9422 TTY 711
District of Columbia | Department of Aging and Community Living 500 K ST NE Washington, DC 20002 https://dcoa.dc.gov/	1-202-724-5626 TTY 711
Delaware | Delaware Medicare Assistance Bureau (DMAB) 1351 WN ST, STE 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711
Florida | Florida Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770
Georgia | GeorgiaCares Senior Health Insurance Plan 2 Peachtree ST NW, FL 33 Atlanta, GA 30303 https://aging.georgia.gov/georgiacares-ship	1-866-552-4464 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Guam | Guam Medicare Assistance Program (GUAM MAP) 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 http://dphss.guam.gov/	1-671-735-7421 TTY 1-671-735-7415
Hawaii | Hawaii SHIP No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	1-888-875-9229 TTY 1-866-810-4379
Iowa | Iowa Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue, STE 100 Des Moines, IA 50315 shiip.iowa.gov	1-800-351-4664 TTY 1-800-735-2942
Idaho | Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State St Boise, ID 83720 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422 TTY 711
Illinois | Illinois Senior Health Insurance Program (SHIP) One Natural Resources Way, STE 100 Springfield, IL 62702-1271 http://www.illinois.gov/aging/ship/Pages/default.aspx	1-800-252-8966 TTY 1-888-206-1327
Indiana | Indiana State Health Insurance Assistance Program (SHIP) 311 W Washington ST, STE 200 Indianapolis, IN 46204-2787 http://www.in.gov/ship	1-800-452-4800 TTY 1-866-846-0139
Kansas | Kansas Senior Health Insurance Counseling for Kansas (SHICK) New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 http://www.kdads.ks.gov/SHICK/shick_index.html	1-800-860-5260 TTY 1-785-291-3167
Kentucky | Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST, 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 TTY 1-800-627-4702

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Louisiana | Louisiana Senior Health Insurance Information Program (SHIIP) P.O. Box 94214 Baton Rouge, LA 70804 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Massachusetts | Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton PL, RM 517 Boston, MA 02108 http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html	1-800-243-4636 TTY 1-800-439-2370
Maryland | Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP) 301 W Preston ST, STE 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425 TTY 711
Maine | Maine State Health Insurance Assistance Program (SHIP) 11 State House Station, 41 Anthony AVE Augusta, ME 04333 https://www.maine.gov/dhhs/oads/community-support/ship.html	1-800-262-2232 TTY 711
Michigan | Michigan MMAP, Inc. Senior Health Insurance Program 6105 W Saint Joseph Highway, STE 204 Lansing, MI 48917 www.mmapinc.org	1-800-803-7174 TTY 711
Minnesota | Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164-0976 https://mn.gov/senior-linkage-line	1-800-333-2433 TTY 1-800-627-3529
Missouri | Missouri CLAIM Senior Health Insurance Program 1105 Lakeview AVE Columbia, MO 65201 www.missouriclaim.org	1-800-390-3330 TTY 711
Northern Mariana Islands | North Mariana Islands Senior Health Insurance Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Mississippi | Mississippi Department of Human Services, Division of Aging & Adult Services 200 S Lamar ST Jackson, MS 39201 http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/	1-601-359-4500 TTY 711
Montana | Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, FL 4 Helena, MT 59601 http://dphhs.mt.gov/sltc/aging/ship	1-800-551-3191 TTY 711
North Carolina | North Carolina Seniors Health Insurance Information Program (SHIIP) 325 N Salisbury ST Raleigh, NC 27603 http://www.ncdoi.com/SHIIP	1-855-408-1212 TTY 711
North Dakota | North Dakota Senior Health Insurance Counseling (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 http://www.nd.gov/ndins/shic/	1-888-575-6611 TTY 1-800-366-6888
Nebraska | Nebraska Senior Health Insurance Information Program (SHIIP) 2717 S. 8th Street, STE 4 Lincoln, NE 68508 https://doi.nebraska.gov/consumer/senior-health	1-800-234-7119 TTY 711
New Hampshire | New Hampshire SHIP - ServiceLink Aging and Disability Resource Center 2 Industrial Park DR, P.O. Box 1016 Concord, NH 03302-1016 https://www.servicelink.nh.gov	1-866-634-9412 TTY 1-800-735-2964
New Jersey | New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/services/ship/index.html	1-800-792-8820 TTY 711
New Mexico | New Mexico Benefits Counseling Program SHIP P.O. Box 27118 Santa Fe, NM 87502-7118 www.nmaging.state.nm.us	1-800-432-2080 TTY 1-505-476-4937

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Nevada | Nevada State Health Insurance Assistance Program (SHIP) 3416 Goni RD, STE D-132 Carson City, NV 89706 http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/	1-800-307-4444 TTY 711
New York | New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, FL 5 Albany, NY 12223 www.aging.ny.gov/health-insurance-information-counseling-and-assistance	1-800-701-0501 TTY 711
Ohio | Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 https://insurance.ohio.gov/wps/portal/gov/odi/consumers	1-800-686-1578 TTY 1-614-644-3745
Oklahoma | Oklahoma Medicare Assistance Program (MAP) 400 NE 50th ST Oklahoma City, OK 73105 www.map.oid.ok.gov	1-800-763-2828 TTY 711
Oregon | Oregon Senior Health Insurance Benefits Assistance (SHIBA) 350 Winter St NE Salem, OR 97309 oregonshiba.org	1-800-722-4134 TTY 711
Pennsylvania | Pennsylvania Senior Health Insurance Program 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 aging.pa.gov	1-800-783-7067 TTY 711
Puerto Rico | Puerto Rico State Health Insurance Assistance Program (SHIP) Ponce de León AVE, PDA 16, EDIF 1064, 3er nivel San Juan, PR 00919-1179 www.oppea.pr.gov	1-787-721-6121 TTY 711
Rhode Island | Rhode Island State Health Insurance Assistance Program (SHIP) 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/	1-401-462-3000 TTY 1-401-462-0740

State Health Insurance Assistance Programs (SHIP) - Contact Information	
South Carolina | South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais ST, STE 350 Columbia, SC 29201 https://aging.sc.gov/	1-800-868-9095 TTY 711
South Dakota | South Dakota Senior Health Information & Insurance Education (SHIINE) 2520 E Franklin St Pierre, SD 57501 www.shiine.net	1-877-331-4834 TTY 711
Tennessee | Tennessee Commission on Aging & Disability - TN SHIP Andrew Jackson BLDG, 502 Deaderick ST, FL 9 Nashville, TN 37243-0860 www.tn.gov/aging/our-programs/state-health-insurance-assistance-program–ship-.html	1-877-801-0044 TTY 711
Texas | Texas Department of Aging and Disability Services (HICAP) P.O. Box 13247 Austin, TX 78711 https://hhs.texas.gov/services/health/medicare	1-800-252-9240 TTY 1-512-424-6597
Utah | Utah Senior Health Insurance Information Program (SHIP) 195 N 1950 W Salt Lake City, UT 84116 https://daas.utah.gov	1-800-541-7735 TTY 711
Virginia | Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest AVE, STE 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402 TTY 711
Virgin Islands of the U.S. | Virgin Islands State Health Insurance Assistance Program (VISHIP) 1131 King ST, STE 101 St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-340-773-6449 TTY 711
Vermont | Vermont State Health Insurance Assistance Program (SHIP) P.O. Box 321 Jericho, VT 05465 www.vermont4a.org	1-800-642-5119 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Washington | Washington Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255 Olympia, WA 98504-0255 www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba	1-800-562-6900 TTY 1-360-586-0241
Wisconsin | Wisconsin State Health Insurance Plan (SHIP) 1402 Pankratz ST, STE 111 Madison, WI 53704 www.longtermcare.wi.gov	1-800-242-1060 TTY 711
West Virginia | West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha BLVD E Charleston, WV 25305 www.wvship.org	1-877-987-4463 TTY 711
Wyoming | Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams AVE Riverton, WY 82501 www.wyomingseniors.com	1-800-856-4398 TTY 711

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

There is a designated Quality Improvement Organization serving Medicare beneficiaries in each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- Alaska - KEPRO
- Alabama - KEPRO
- Arkansas - KEPRO
- American Samoa - Livanta BFCC-QIO Program
- Arizona - Livanta BFCC-QIO Program
- California - Livanta BFCC-QIO Program
- Colorado - KEPRO
- Connecticut - KEPRO
- District of Columbia - Livanta BFCC-QIO Program
- Delaware - Livanta BFCC-QIO Program
- Florida - KEPRO
- Georgia - KEPRO
- Guam - Livanta BFCC-QIO Program
- Hawaii - Livanta BFCC-QIO Program

- Iowa - Livanta BFCC-QIO Program
- Idaho - KEPRO
- Illinois - Livanta BFCC-QIO Program
- Indiana - Livanta BFCC-QIO Program
- Kansas - Livanta BFCC-QIO Program
- Kentucky - KEPRO
- Louisiana - KEPRO
- Massachusetts - KEPRO
- Maryland - Livanta BFCC-QIO Program
- Maine - KEPRO
- Michigan - Livanta BFCC-QIO Program
- Minnesota - Livanta BFCC-QIO Program
- Missouri - Livanta BFCC-QIO Program
- Northern Mariana Islands - Livanta BFCC-QIO Program
- Mississippi - KEPRO
- Montana - KEPRO
- North Carolina - KEPRO
- North Dakota - KEPRO
- Nebraska - Livanta BFCC-QIO Program
- New Hampshire - KEPRO
- New Jersey - Livanta BFCC-QIO Program
- New Mexico - KEPRO
- Nevada - Livanta BFCC-QIO Program
- New York - Livanta BFCC-QIO Program
- Ohio - Livanta BFCC-QIO Program
- Oklahoma - KEPRO
- Oregon - KEPRO
- Pennsylvania - Livanta BFCC-QIO Program
- Puerto Rico - Livanta BFCC-QIO Program
- Rhode Island - KEPRO
- South Carolina - KEPRO
- South Dakota - KEPRO
- Tennessee - KEPRO
- Texas - KEPRO
- Utah - KEPRO
- Virginia - Livanta BFCC-QIO Program
- Virgin Islands of the U.S. - Livanta BFCC-QIO Program
- Vermont - KEPRO
- Washington - KEPRO
- Wisconsin - Livanta BFCC-QIO Program
- West Virginia - Livanta BFCC-QIO Program
- Wyoming - KEPRO

Your state's Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to

check on and help improve the quality of care for people with Medicare. The state's Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact your state's Quality Improvement Organization in any of these situations:

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

Quality Improvement Organization (QIO) – Contact Information	
Alaska | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Alabama | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Arkansas | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
American Samoa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668
Arizona | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
California | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Colorado | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Connecticut | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
District of Columbia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Delaware | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Florida | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Georgia | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Guam | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Hawaii | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Iowa | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Idaho | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Illinois | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Indiana | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Kansas | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Kentucky | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Louisiana | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Massachusetts | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Maryland | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Maine | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Michigan | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Minnesota | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Missouri | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Northern Mariana Islands | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668
Mississippi | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Montana | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
North Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
North Dakota | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 https://www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Nebraska | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 TTY 1-888-985-9295 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
New Hampshire | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
New Jersey | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 1-866-868-2289 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
New Mexico | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Nevada | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 TTY 1-855-887-6668 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
New York | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 1-866-868-2289 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Ohio | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Oklahoma | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Oregon | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Pennsylvania | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Puerto Rico | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 1-866-868-2289 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Rhode Island | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
South Carolina | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
South Dakota | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Tennessee | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Texas | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Utah | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Virgin Islands of the U.S. | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 1-866-868-2289
Vermont | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-319-8452 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Washington | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-305-6759 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Quality Improvement Organization (QIO) – Contact Information	
Wisconsin | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 TTY 1-888-985-8775 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
West Virginia | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 TTY 1-888-985-2660 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
Wyoming | KEPRO 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0891 TTY 711 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays

Section 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
Call	**1-800-772-1213** Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778**

Method	Social Security – Contact Information
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
Website	**www.ssa.gov**

Section 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.
In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

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

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

State Medicaid Programs – Contact Information	
Alaska | State of Alaska Department of Health & Social Services, Division of Health Care Services 4501 Business Park BLVD, BLDG L Anchorage, AK 99503-7167 http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx	1-800-770-5650 TTY 1-907-465-5430
Alabama | Alabama Medicaid P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 711

State Medicaid Programs – Contact Information	
Arkansas | Arkansas Division of Medical Services Department of Human Services Donaghey Plaza S, P.O. Box 1437 Slot S401 Little Rock, AR 72203-1437 https://medicaid.mmis.arkansas.gov	1-800-482-8988 TTY 1-800-285-1131
American Samoa | American Samoa Medicaid State Agency ASCTA Executive BLDG #304, P.O. Box 998383 Pago Pago, AS 96799 http://medicaid.as.gov/	1-684-699-4777 TTY 711
Arizona | Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson ST Phoenix, AZ 85034 www.azahcccs.gov	1-855-432-7587 TTY 1-800-367-8939
Arizona | Arizona Department of Economic Security / Division of Developmental Disabilities (DDD) 1789 W Jefferson ST Phoenix, AZ 85007 https://des.az.gov/services/disabilities/developmental-disabilities	1-844-770-9500 TTY 711
California | Medi-Cal - Managed Care Operations Division Department of Health Care Services P.O. Box 989009 West Sacramento, CA 95798-9850 https://www.healthcareoptions.dhcs.ca.gov/	1-800-430-4263 TTY 1-800-430-7077
Colorado | Colorado Department of Health Care Policy and Financing 1570 Grant ST Denver, CO 80203-1818 www.healthfirstcolorado.com	1-800-221-3943 TTY 711
Connecticut | Connecticut State Medicaid 55 Farmington AVE Hartford, CT 06105-3730 portal.ct.gov/husky	1-877-284-8759 TTY 1-866-492-5276
District of Columbia | DC Department of Human Services 64 New York AVE NE, FL 6 Washington, DC 20002 https://dhs.dc.gov/service/medical-assistance	1-202-671-4200 TTY 711
Delaware | Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 http://dhss.delaware.gov/dhss/	1-302-255-9040 TTY 711

State Medicaid Programs – Contact Information	
Florida | Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 https://ahca.myflorida.com/	1-888-419-3456 TTY 1-800-955-8771
Georgia | Georgia Department of Community Health 1249 Donald Lee Hollowell Parkway Atlanta, GA 30318 https://medicaid.georgia.gov/	1-877-423-4746 TTY 711
Guam | Guam Department of Public Health and Social Services Bureau of Health Care Financing 123 Chalan Kareta Mangilao, GU 96913-6304 http://www.dphss.guam.gov/	1-671-735-7243 TTY 711
Hawaii | Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 https://humanservices.hawaii.gov/	1-808-586-5390 TTY 711
Iowa | Department of Human Services (Iowa Medicaid Enterprise) 1305 E Walnut Street FL 5 Des Moines, IA 50319 http://dhs.iowa.gov/	1-800-338-8366 TTY 1-800-735-2942
Idaho | Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0026 https://healthandwelfare.idaho.gov	1-877-456-1233 TTY 1-888-791-3004
Illinois | Illinois Department of Healthcare and Family Services 100 S Grand AVE E Springfield, IL 62704 http://www2.illinois.gov/hfs/	1-800-843-6154 TTY 1-800-447-6404
Indiana | Indiana Family and Social Services Administration FSSA Document CTR, P.O. Box 1810 Marion, IN 46952 https://www.in.gov/medicaid/	1-800-403-0864 TTY 1-800-743-3333
Kansas | Kansas Dept. of Health and Environment 900 SW Jackson ST Topeka, KS 66612 http://www.kancare.ks.gov/	1-800-792-4884 TTY 711
Kentucky | Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 https://chfs.ky.gov/	1-800-635-2570 TTY 711

State Medicaid Programs – Contact Information	
Louisiana | Louisiana Department of Health 628 N 4th Street Baton Rouge, LA 70802 https://ldh.la.gov/	1-225-342-9500 TTY 711
Massachusetts | Executive Office of Health and Human Services 100 Hancock ST, FL 6 Quincy, MA 02171 http://www.mass.gov/eohhs/gov/departments/masshealth/	1-800-841-2900 TTY 1-800-497-4648
Maryland | Maryland Department of Health 201 W Preston ST Baltimore, MD 21201-2399 https://health.maryland.gov/pages/index.aspx	1-877-463-3464 TTY 1-800-735-2258
Maine | Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711
Michigan | Department of Health and Human Services 333 S Grand AVE, P.O. Box 30195 Lansing, MI 48909 http://www.michigan.gov/mdhhs/	1-517-373-3740 TTY 1-800-649-3777
Minnesota | Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 http://mn.gov/dhs	1-800-657-3739 TTY 1-800-627-3529
Missouri | MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102-6500 https://www.dss.mo.gov/mhd/	1-573-526-4274 TTY 1-800-735-2966
Northern Mariana Islands | State Medicaid Administration Office Government BLDG # 1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 http://medicaid.cnmi.mp/	1-670-664-4880 TTY 711
Mississippi | State of Mississippi Division of Medicaid 550 High ST STE, 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711

State Medicaid Programs – Contact Information	
Montana | Montana Healthcare Programs P.O. Box 202951 Helena, MT 59620-2951 https://dphhs.mt.gov/MontanaHealthcarePrograms	1-406-444-4455 TTY 1-800-833-8503
North Carolina | Division of Medical Assistance 2501 Mail Service CTR Raleigh, NC 27699-2501 https://dma.ncdhhs.gov/medicaid	1-888-245-0179 TTY 1-877-452-2514
North Dakota | North Dakota Department of Human Services 600 E BLVD AVE, Department 325 Bismarck, ND 58505-0250 http://www.nd.gov/dhs/services/medicalserv/medicaid	1-800-755-2604 TTY 1-800-366-6888
Nebraska | Nebraska Department of Health and Human Services 301 Centennial Mall S Lincoln, NE 68509 http://dhhs.ne.gov/Pages/default.aspx	1-402-471-3121 TTY 711
New Hampshire | New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301-3852 https://www.dhhs.nh.gov/ombp/medicaid/	1-603-271-4344 TTY 1-800-735-2964
New Jersey | Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/	1-800-701-0710 TTY 711
New Mexico | NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hsd.state.nm.us/	1-888-997-2583 TTY 1-855-227-5485
Nevada | Nevada Department of Health and Human Services 1100 E Williams ST, STE 101 Carson City, NV 89701 http://dhcfp.nv.gov	1-800-992-0900 TTY 711
New York | New York State Department of Health Corning Tower, Empire State Plaza Albany, NY 12237 http://www.health.state.ny.us/health_care/medicaid/index.htm	1-800-541-2831 TTY 711
Ohio | Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215 https://medicaid.ohio.gov/	1-800-324-8680 TTY 711

State Medicaid Programs – Contact Information	
Oklahoma | Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 http://www.okhca.org	1-800-987-7767 TTY 711
Oregon | Oregon Health Authority 500 Summer ST, NE, E-20 Salem, OR 97301-1097 https://www.oregon.gov/oha/HSD/OHP	1-503-947-2340 TTY 711
Pennsylvania | Pennsylvania Department of Human Services P.O. Box 5959 Harrisburg, PA 17110-0959 http://www.dhs.pa.gov/	1-800-692-7462 TTY 1-800-451-5886
Puerto Rico | Government of Puerto Rico, Department of Health Medicaid Program P.O. Box 70184 San Juan, PR 00936-8184 https://medicaid.pr.gov	1-787-765-2929 TTY 1-787-625-6955
Rhode Island | Executive Office of Health and Human Services (EOHHS) 3 West Road Cranston, RI 02920 http://www.eohhs.ri.gov/	1-401-462-5274 TTY 711
South Carolina | South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620
South Dakota | South Dakota Department of Social Services, Division of Medical Services 700 Governors DR Pierre, SD 57501 http://dss.sd.gov/medicaid/	1-800-597-1603 TTY 711
Tennessee | Division of TennCare 310 Great Circle RD Nashville, TN 37243 https://www.tn.gov/tenncare/	1-800-342-3145 TTY 711
Texas | Texas Medicaid Health and Human Services Commission 4900 N Lamar BLVD, P.O. Box 13247 Austin, TX 78751 https://hhs.texas.gov/about-hhs/find-us	1-512-424-6500 TTY 1-512-424-6597

State Medicaid Programs – Contact Information	
Utah | Utah Department of Health, Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 711
Virginia | Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 http://www.dmas.virginia.gov/	1-855-242-8282 TTY 711
Virgin Islands of the U.S. | U.S. Virgin Islands Bureau of Health Insurance & Medical Assistance 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 www.dhs.gov.vi	1-340-715-6929 TTY 711
Vermont | Department of Vermont Health Access 280 ST DR Waterbury, VT 05671 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711
Washington | Washington State Health Care Authority P.O. Box 45531 Olympia, WA 98504 www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage	1-800-562-3022 TTY 711
Wisconsin | Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/health-care-coverage/index.htm	1-800-362-3002 TTY 711
West Virginia | West Virginia Bureau for Medical Services 350 Capitol ST, RM 251 Charleston, WV 25301 http://www.dhhr.wv.gov/bms/Pages/default.aspx	1-304-558-1700 TTY 711
Wyoming | Wyoming Department of Health 6101 Yellowstone RD, STE 210 Cheyenne, WY 82009 http://health.wyo.gov/healthcarefin/medicaid/	1-307-777-7531 TTY 1-855-329-5205

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say “Medicaid” for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov for more information.

Section 7 How to contact the Railroad Retirement Board

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

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

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

Section 8 Do you have "group insurance" or other health insurance from an employer outside of TRS-Care?

If you (or your spouse) have medical or prescription drug coverage through another employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current coverage will work with our plan. You can also call Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

Chapter 3

Using the plan's coverage for your medical services

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

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

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

Because you are a member of the TRS-Care Medicare Advantage plan, you can see any provider (network or out-of-network) at the same cost share, as long as they accept Medicare and are willing to bill UnitedHealthcare.

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

Section 1.1 What are "network providers" and "covered services"?

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

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Primary Care Provider"** (PCP) is a network physician who is selected by you to provide and coordinate your covered services. PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, TRS-Care Medicare Advantage must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

The plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).

- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the **Provider Directory.**
  - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

Section 2 Using network and out-of-network providers to get your medical care

As a member of the TRS-Care Medicare Advantage plan, you may see doctors and other health care professionals, medical groups, hospitals, and other health care facilities that are not contracted with UnitedHealthcare, as long as they accept Medicare and are willing to bill UnitedHealthcare, and as long as the services are covered benefits and are medically necessary. **Unlike most PPO plans, with this plan you pay the same cost share for in-network and out-of-network services.**

Section 2.1 How to get care from specialists and other network providers

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

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

How to access your behavioral/mental health benefit

To directly access your behavioral/mental health benefits, please call the number on your TRS-Care Medicare Advantage member ID card 24 hours a day, 7 days a week. When you call, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you are experiencing and assess which provider and treatment would be appropriate for your situation. You may also ask your Primary Care Provider (PCP) to call the number on your TRS-Care Medicare Advantage member ID card and arrange a referral on your behalf. You may also call to receive information about **network practitioners,** subspecialty care and obtaining care after normal office hours. Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

What if a specialist or another network provider leaves our plan?
It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If this happens, you may continue to see the provider as long as he/she continues to accept the plan and has not opted out of or been excluded or precluded from the Medicare Program, and the care you receive is a covered service and is medically necessary. Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists. When possible, we will provide you with at least 30 days' notice that your network provider is leaving our plan.

You may call Customer Service for assistance at the number listed in Chapter 2 of this booklet.

Some services require prior authorization from the plan in order to be covered. Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in Medical Benefits Chart in Chapter 4, Section 2.1.

Section 2.2 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Because you are a member of the TRS-Care Medicare Advantage plan, **you can see any provider (network or out-of-network) that accepts Medicare and is willing to bill UnitedHealthcare, at the same cost share.** Here are other 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 cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 **(What to do if you have a problem or complaint)** to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us

for payment. See Chapter 5 **(Asking us to pay our share of a bill you have received for covered medical services)** for information about what to do if you receive a bill or if you need to ask for reimbursement.

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

Section 3.1 Getting care if you have a medical emergency

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

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the world. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you receive emergency or urgently-needed services outside of the United States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan.

What if it wasn't a medical emergency?

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

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

What are "urgently needed services"?

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

Our plan covers worldwide emergency and urgently needed services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.UHCRetiree.com/TRS-CareMA for information on how to obtain needed care during a disaster.

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

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

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

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

Our plan covers all medical services that are medically necessary. These services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** has more information about what to do if you want a coverage decision from us or

want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if your plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your plan's out-of-pocket maximum.) You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

Not all clinical research studies are open to members of our plan. Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the plan will cover the Part A related costs of your participation in a research study. (Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.) Medicare first needs to approve the research study. If you participate in a study that Medicare has **not** approved, **you will be responsible for paying all costs for your participation in the study.**

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan. Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the plan will pay the Part A costs related to a Medicare-covered clinical research study.

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

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study**.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

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

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

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

Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the plan will pay the Part A related costs related to a Medicare-covered clinical research study.

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

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

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

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

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

Do you want to know more?

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

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

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

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

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

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

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

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

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

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. The coverage limits are described under **Inpatient Hospital Care** in the Medical Benefits Chart in Chapter 4.

Section 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the

home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are printed on the cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

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

Section 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, our plan 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 our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost-sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 5% coinsurance, every time you get covered equipment or supplies.

Your cost-sharing will not change after being enrolled for 36 months in our plan.

If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in our plan is 5% coinsurance.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining our plan, join our plan for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in our plan and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Chapter 4

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

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

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of TRS-Care Medicare Advantage. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- The "**deductible**" is the amount you must pay for certain medical services before our plan begins to pay its share. Section 1.2 tells you more about your plan deductible.
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

Section 1.2 What is your plan deductible?

Your combined in-network and out-of-network medical deductible is $500. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services that are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the plan year.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services.

- Allergy Injections or Serums
- Ambulance Services
- Blood
- Compression Stockings (Medicare-covered)
- Compression Stockings (Non-Medicare covered)

- Diabetes Monitoring Supplies
- Emergency Care (includes Worldwide Coverage)
- Hospice Care (Medicare-covered)
- Omnipod insulin delivery system and supplies (Non-Medicare covered)
- Opioid Treatment Services
- Outpatient Mental Health/Substance Abuse (Group Visit)
- Outpatient Mental Health/Substance Abuse (Individual Visit)
- Part B Drugs - Chemotherapy (when purchased at a pharmacy)
- Part B Drugs - Immunosuppressives, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigens (when purchased at a pharmacy)
- Preventive Services:
  - Abdominal Aortic Aneurysm Screening (Medicare-covered)
  - Annual Routine Physical Exam
  - Annual Wellness Visit and one-time Welcome to Medicare Preventive Visit (Medicare-covered)
  - Bone Mass Measurement (Medicare-covered)
  - Breast Cancer Screening (Mammograms) (Medicare-covered)
  - Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) (Medicare-covered)
  - Cardiovascular Disease Testing (Medicare-covered)
  - Colorectal Cancer Screenings (Medicare-covered)
  - Depression screening (Medicare-covered)
  - Diabetes Screening and Monitoring (Medicare-covered)
  - Diabetes – Self Management Training (Medicare-covered)
  - Dialysis Training (Medicare-covered)
  - Glaucoma Screening (Medicare-covered)
  - Hepatitis C Screening (Medicare-covered)
  - HIV Screening (Medicare-covered)
  - Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines) - (Medicare-covered)
  - Kidney Disease Education (Medicare-covered)
  - Lung Cancer Screening (Medicare-covered)
  - Medical Nutrition Therapy and Counseling Services (Medicare-covered)
  - Obesity screening and therapy to promote sustained weight loss (Medicare-covered)
  - Pap Tests and Pelvic Exams (Medicare-covered)
  - Prostate Cancer Screening Exams (Medicare-covered)
  - Screening and Counseling to Reduce Alcohol Misuse (Medicare-covered)

- Screening for Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs (Medicare-covered)
- Smoking and Tobacco Use Cessation (Counseling to Stop Smoking or Tobacco Use) (Medicare-covered)

- Primary care provider (PCP) office visit
- Routine Hearing Services and Hearing Aids
- Routine Vision Services - Routine Eye Exam
- Telehealth
- Urgently Needed Services (in-network)
- Urgently Needed Services (out-of-network)
- Virtual Behavioral Visits
- Virtual Cognitive Behavioral Health Therapy (AbleTo Program)
- Virtual Doctor Visits
- Vision Services - Diabetic Eye Exam (Medicare-covered)
- Vision Services - Eyewear allowance for Frames and Lenses or Contacts (Medicare-covered after cataract surgery)
- Wigs (as covered in the Medical Benefits Chart)

Section 1.3 What is the most you will pay for Medicare covered medical services?

- Your **combined maximum out-of-pocket amount** is $3,500. This is the most you pay during the plan year for covered Medicare services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this 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 $3,500 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the plan year for services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of TRS-Care Medicare Advantage, an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00) then you pay only that amount for any covered services from a network provider.

- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- See your cost-sharing amounts in the medical benefits chart in section 2.1 below.
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the cover of this booklet).

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

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

The Medical Benefits Chart on the following pages lists the services TRS-Care Medicare Advantage covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) **must** be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the in-network services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us.
  - Covered services that may need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart.
  - Network providers agree by contract to obtain prior authorization from the plan and agree to not balance bill you.
  - 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.

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 receive the services from:

- If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Original Medicare Limiting Charge.

- See your cost-sharing amounts in the medical benefits chart in section 2.1 below
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay **more** in our plan than you would in Original Medicare. For others, you pay **less**. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2022** Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition. See the Medical Benefits Chart for information about your share of the **out-of-network** costs for these services.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

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

Medically Necessary - means health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your sickness, injury or illness that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with **Generally Accepted Standards of Medical Practice**.
- Most appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, or illness.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Meet, but do not exceed your medical need, are at least as beneficial as an existing and available medically appropriate alternative, and are furnished in the most cost-effective manner that may be provided safely and effectively.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available,

observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: • Your doctor will ask for a copayment for the office visit and additional copayments for each x-ray that is performed while you are there. • Your hospital will ask for separate cost sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there. • The specific cost sharing that will apply depends on which services you receive. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.		
Abdominal Aortic Aneurysm Screening A one-time (once per lifetime) screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse	5% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.	5% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: □ a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, □ a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. □ Benefit is not covered when solely provided by an independent acupuncturist. 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 □ Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility	5% coinsurance for each one-way Medicare-covered trip. You pay these amounts until you reach the out-of-pocket maximum.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. □ Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	*Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation. Emergency Ambulance does not require authorization.*	
Annual Routine Physical Exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Benefit is combined in and out-of-network.	$0 copayment for a routine physical exam each year.	$0 copayment for a routine physical exam each year.
Annual Wellness Visit	There is no coinsurance, copayment, or	There is no coinsurance, copayment, or

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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. You don't have to wait a full year to get your annual wellness visit, you can get it once every calendar year. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **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.	deductible for the annual wellness visit.	deductible for the annual wellness visit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Bone Mass Measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast Cancer Screening (Mammograms) Covered services include: □ One baseline mammogram between the ages of 35 and 39 □ One screening mammogram every 12 months for women age 40 and older □ Clinical breast exams once every 24 months A screening mammography is used for the early detection of breast cancer in women who have no signs or symptoms of the disease. Once a history of breast cancer has been established, and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are subject to cost sharing as described	There is no coinsurance, copayment, or deductible for covered screening mammograms.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefit is not available for members who have signs or symptoms of breast cancer.		
Cardiac Rehabilitation Services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.	$10 copayment for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.
Intensive Cardiac Rehabilitation Services The plan covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$10 copayment for each Medicare-covered intensive cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered intensive cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.
Cardiovascular Disease Testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Cervical and Vaginal Cancer Screening Covered services include: □ For all women: Pap tests and pelvic exams are covered once every 24 months □ If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months □ For asymptomatic women between the ages of 30 and 65: HPV Testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic Services Covered services include: □ Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). □ Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation.	5% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.
Routine Chiropractic Services Includes 20 visits per plan year.	5% coinsurance for each visit.	5% coinsurance for each visit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Please turn to Section 4 Routine Chiropractic Services of this chapter for more detailed information about this chiropractic benefit.		Benefit is combined in and out-of-network.
Colorectal Cancer Screening For people 50 and older, the following are covered: □ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: □ Guaiac-based fecal occult blood test (gFOBT) □ Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: □ Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: □ Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam and colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema. If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the Outpatient Surgery cost sharing in this chart. Therefore, the screening colonoscopy benefit is not available for members who have	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam and colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema. If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the Outpatient Surgery cost sharing in this chart. Therefore, the screening colonoscopy benefit is not available for members who have

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient diagnostic colonoscopy	signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient Surgery cost sharing described later in this chart. $250 copayment for each Medicare-covered diagnostic colonoscopy. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient Surgery cost sharing described later in this chart. $250 copayment for each Medicare-covered diagnostic colonoscopy. You pay these amounts until you reach the out-of-pocket maximum.
Compression Stockings (Non-Medicare-Covered) Includes unlimited coverage of certain stockings per plan year.	$0 copayment	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Depression Screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes Screening and Monitoring We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every plan year.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes Self-Management Training, Diabetic Services and Supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ 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. TRS-Care Medicare Advantage covers any blood glucose monitors and test strips specified within this list. We will generally not cover alternate brands unless your doctor or other provider tells us that use of an alternate brand is medically necessary in your specific situation. If you are new to TRS-Care Medicare Advantage and are using a brand of blood glucose monitors and test strips that is not on our list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate brand while you consult with your doctor or other provider. During this time, you should talk with your doctor to decide whether any of the preferred brands are medically appropriate for you. If you or your doctor believe it is medically necessary for you to maintain use of an alternate brand, you may request a coverage exception to have TRS-Care Medicare Advantage maintain coverage of a non-preferred product through the end of the benefit	$0 copayment for each Medicare-covered diabetes monitoring supply. We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan. *Your provider may need to obtain prior authorization* Insulin and syringes are not covered.	$0 copayment for each Medicare-covered diabetes monitoring supply. We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan. Insulin and syringes are not covered.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
year. Non-preferred products will not be covered following the initial 90 days of the benefit year without an approved coverage exception. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 7, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).)		
Continuous Glucose Monitor (CGM)		
○ Medicare-covered therapeutic CGMs and supplies are covered for people with diabetes on intensive insulin therapy.	$0 copayment for Medicare-covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies. *Your provider may need to obtain prior authorization*	$0 copayment for Medicare-covered Therapeutic Continuous Glucose Monitors (CGMs) and supplies.
○ Non-Medicare covered non-therapeutic CGMs and supplies.	$0 copayment for non-Medicare covered non-therapeutic CGMs and supplies.	$0 copayment for non-Medicare covered non-therapeutic CGMs and supplies.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ **For people with diabetes who have severe diabetic foot disease**: One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	$0 copayment for each pair of Medicare-covered therapeutic shoes. *Your provider may need to obtain prior authorization*	$0 copayment for each pair of Medicare-covered therapeutic shoes.
□ **Diabetes self-management training** is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	$0 copayment for Medicare-covered benefits.	$0 copayment for Medicare-covered benefits.
□ **Omnipod insulin delivery system and supplies** (Non-Medicare covered)	$0 copayment	$0 copayment

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Durable Medical Equipment (DME) and Related Supplies (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.UHCRetiree.com/TRS-CareMA.	5% coinsurance for Medicare-covered benefits, except for insulin pumps and associated supplies. $0 copayment for insulin pumps and associated supplies. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for Medicare-covered benefits, except for insulin pumps and associated supplies. $0 copayment for insulin pumps and associated supplies. You pay these amounts until you reach the out-of-pocket maximum.
Non-Medicare-Covered Durable Medical Equipment and Related Supplies Covered items include non-Medicare-covered non-therapeutic Continuous Glucose Monitors (CGM) and supplies.	$0 copayment for non-Medicare covered non-therapeutic CGMs and supplies.	
Emergency Care Emergency care refers to services that are:	$65 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost sharing	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Furnished by a provider qualified to furnish emergency services, and □ Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	as described in the "Inpatient Hospital Care" section in this benefit chart. You pay these amounts until you reach the out-of-pocket maximum.	
Worldwide coverage for emergency department services. □ This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. □ Transportation back to the United States from another country is not covered.	$65 copayment for worldwide coverage for emergency services. You do not pay this amount if admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost sharing as described in the Inpatient Hospital Care section in this benefit chart. Please see Chapter 5 Section 1.1 for expense reimbursement for worldwide services. You pay these amounts until you reach the out-of-pocket maximum.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. □ Services provided by a dentist are not covered.		
Over-the-counter care FirstLine Essentials+ You will receive $40 quarterly (January, April, July and October) to purchase personal health care items from the FirstLine Essentials+ website or catalog. Items are delivered to your home at no additional cost. The quarterly credit may be carried over from month to month, but all credits must be used by December 31. Orders must total $30 or more. There is no limit on the number of orders you can place. To access your benefit please call 866-868-2491, 7 a.m. – 7 p.m. CT, Monday – Friday & 7 a.m. – 4 p.m. CT Saturday, visit www.ShopFirstLineBenefits.TRS-CareMA.com or refer to the program materials.	$0 copayment	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Fitness program SilverSneakers® SilverSneakers® is a Medicare fitness program and includes: □ A $0 membership fee for a standard, monthly membership at a participating fitness center. □ Access to group exercise classes at participating locations. □ Access to SilverSneakers FLEX® classes to get active outside of traditional gyms. □ A support network and virtual resources through SilverSneakers Live, SilverSneakers On-Demand™ and the mobile app SilverSneakers GO™. □ The option to join the SilverSneakers Steps Program if you live 15 miles or more from a SilverSneakers fitness center. With this program, you choose 1 of 4 kits that best fits your lifestyle and fitness level: general fitness, strength, walking, or yoga.	You have access to SilverSneakers® at no additional cost. To get your SilverSneakers ID number or learn more about this benefit, call 1-888-423-4632, TTY 711, 7 a.m. to 7 p.m. CT, Monday through Friday, or visit SilverSneakers.com	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
UnitedHealthcare Healthy at Home post-discharge program You are eligible for the following benefits up to 30 days following all inpatient and skilled nursing facility discharges: **Home-Delivered Meals** Receive 28 home-delivered meals when referred by a UnitedHealthcare Advocate. □ All meals must be ordered in succession and cannot be spread out over the course of the year. □ Meals are sent in shipments of 14 meals or greater and can be refrigerated for up to 14 days. □ The first meal delivery may take up to 72 hours upon order. □ Some restrictions and limitations may apply. □ If you have been recently discharged from the hospital or a skilled nursing facility and would like to be referred into the benefit call the phone number located on the back of your TRS-Care Medicare Advantage member ID card. □ Contact Mom's Meals for additional details and to place your	$0 copayment; Benefit is available through the following provider: Mom's Meals, ModivCare, and CareLinx.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
meal orders if you have been referred into the program. 1-866-204-6111, 7 a.m. - 6 p.m. CT, Monday – Friday **Non-emergency transportation** Receive 12 one-way rides to medically related appointments and to the pharmacy when referred by a UnitedHealthcare Advocate. • New referrals are required following each discharge. • Pick-up to or from plan approved medically related appointments (locations); limited to ground transportation only. • Mileage reimbursement available upon request (arrangements must be set up in advance by contacting ModivCare. • Each one-way trip must not exceed 50 miles. A trip is considered one way; a round trip is considered two trips. • The benefit cannot be used for emergency related trips. Please reach out to ModivCare for a comprehensive list of plan approved locations.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
☐ Benefit allows up to one companion per trip at least 18 years of age or older. ☐ Cab/Sedan services available. ☐ Standard transportation services require at least 2 business days advanced notice. ☐ Appointments can be made up to 30 days in advance. Note: Drivers do not have medical training. In case of an emergency, call 911. If you have been recently discharged from the hospital or a skilled nursing facility and would like to be referred into the benefit call the phone number located on the back of your TRS-Care Medicare Advantage member ID card. Contact ModivCare for additional details and to schedule your trip once you have been referred into the program: 1-833-219-1182, TTY 1-844-488-9724, 8 a.m.- 5 p.m. Local Time, Monday - Friday, or by visiting www.modivcare.com/BookNow ***weekend scheduling available only for urgent requests as specified by ModivCare**		
In-home Personal Care		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Receive 6 hours of in-home personal care through our exclusive national provider CareLinx □ CareLinx professional caregivers perform tasks such as preparing meals, bathing, medication reminders, and providing transportation around your community. □ A referral is not required, simply contact CareLinx directly to begin accessing your benefit once you have been discharged. □ Unused hours do not roll over. □ Caregiver hours must be scheduled in 2 hour increments. □ You will typically be paired with a caregiver within 5 business days. □ Some restrictions and limitations apply. To access your in-home personal care benefit, contact CareLinx at 1-844-383-0411 8 a.m. - 7 p.m. CT, Monday - Friday & 10 a.m. - 6 p.m. CT, Saturday and Sunday, or by visiting www.carelinx.com/UHC-retiree-post-discharge You are not required to use all three services		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ New referrals for meals and transportation benefits are required following each discharge. □ Benefits can only be used within 30 days of your hospital or skilled nursing facility discharge. □ Unused benefits do not roll over.		
Hearing Services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
Routine Hearing Services Please turn to Section 4 Hearing Services of this chapter for more detailed information about this hearing services benefit.	**Hearing Exam** $0 copayment for 1 exam per plan year. **Hearing Aids** **(Includes digital hearing aids)** Through UnitedHealthcare Hearing, receive a broad selection of name brand and private-labeled hearing aids custom-programmed for your	**Hearing Exam** $0 copayment 1 exam per plan year. Benefit is combined in and out-of-network. **Hearing Aids** **(Includes digital hearing aids)** Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.*

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	hearing loss. Hearing aids can be fit in-person, or delivered directly to your home through the Right2you direct delivery with follow-up virtual care (select products only). To access your hearing aid benefits, you must contact UnitedHealthcare Hearing at 1-888-547-1374, TTY 711. The plan pays up to a $500 allowance (combined for both ears) for hearing aids every 3 years.*	
Hepatitis C Screening For people that meet one of the following conditions: □ High risk because of current or past history of illicit injection drug use □ Had a blood transfusion before 1992 □ Born between 1945 – 1965	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered Hepatitis C screening.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered Hepatitis C screening.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Screening is covered annually only for high risk people with continued illicit drug use since the prior negative screening test. Screening is covered once in a lifetime for people that were born between 1945 and 1965, who are not considered high risk.		
HIV Screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: □ One screening exam every 12 months For women who are pregnant, we cover: □ Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home Health Agency Care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for	$0 copayment for all home health visits provided by a home health agency when Medicare criteria are met. Other copayments or coinsurance may apply (Please see Durable Medical Equipment and Related Supplies for

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) □ Physical therapy, occupational therapy, and speech therapy □ Medical and social services □ Medical equipment and supplies	applicable copayments or coinsurance). *Your provider may need to obtain prior authorization*	applicable copayments or coinsurance).
Home Infusion Therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: □ Professional services, including nursing services, furnished in accordance with the plan of care	$0 copayment for home infusion therapy administration or monitoring services. *Your provider may need to obtain prior authorization* See "Durable Medical Equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum.	$0 copayment for home infusion therapy administration or monitoring services. See "Durable Medical Equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to Home Infusion Therapy. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Patient training and education not otherwise covered under the durable medical equipment benefit □ Remote monitoring □ Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	*Your provider may need to obtain prior authorization* See "Medicare Part B Prescription Drugs" later in this chart for any applicable cost-sharing for drugs related to Home Infusion Therapy. *Your provider may need to obtain prior authorization*	See "Medicare Part B Prescription Drugs" later in this chart for any applicable cost-sharing for drugs related to Home Infusion Therapy.
Hospice Care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: □ Drugs for symptom control and pain relief □ Short-term respite care □ Home care	When you 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 TRS-Care Medicare Advantage. **Note:** If you are not entitled to Medicare Part A coverage, hospice services are not covered by the plan or by Medicare. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost sharing amount for these services. Please refer to this Benefits Chart. For services that are covered by TRS-Care Medicare Advantage but are not covered by Medicare Part A or B: TRS-Care Medicare Advantage will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. Our plan covers hospice consultation services (one time only) for a terminally		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: □ Pneumonia vaccine □ Flu vaccine, one each flu season in the fall and winter, with additional flu vaccine shots if medically necessary □ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B □ COVID-19 vaccine □ Other vaccines if you are at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered Immunizations.	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered Immunizations.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
In-Home Non-Medical Care You are eligible for 8 hours per month of in-home non-medical care offered through CareLinx. CareLinx professional caregivers perform tasks such as preparing meals, bathing, medication reminders, and providing transportation around your community. Unused hours do not roll over. Caregiver hours must be scheduled in 2 hour increments. You will typically be paired with a caregiver within 5 business days. Some restrictions and limitations apply. To access your benefit, contact CareLinx at 1-888-912-9435 8 a.m. - 7 p.m. CT, Monday - Friday & 10 a.m. - 6 p.m. CT, Saturday and Sunday, or by visiting www.carelinx.com/trs-care-ma.	$0 copayment; Benefit is available through our national provider CareLinx.	
Inpatient Hospital Care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include, but are not limited to:	$500 copayment for each Medicare-covered hospital stay each time you are admitted. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$500 copayment for each Medicare-covered hospital stay each time you are admitted. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ 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. □ 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. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the	Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.	of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call TRS-Care Medicare Advantage Customer Service at 1-866-347-9507 TTY 711. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If TRS-Care Medicare Advantage provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/coach airfare, taxi fares, or rideshare services.) Costs for lodging or places to stay such as hotels, motels or short-term housing as a result of travel for a covered organ transplant may also be covered. You can be reimbursed for eligible costs up to $125 per day total. Transportation services are not subject to the daily limit amount. □ Blood - including storage and administration. Coverage begins with the first pint of blood that you need. □ Physician services		
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an inpatient or	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		
Inpatient Mental Health Care Covered services include: □ Mental health care services that require a hospital stay. □ Inpatient substance abuse services	$500 copayment per Medicare-covered admission. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization* Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing	$500 copayment per Medicare-covered admission. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. For each inpatient

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	described above applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.	hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.
Inpatient Stay: Covered services received in a hospital or Skilled Nursing Facility (SNF) during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:	When your stay is no longer covered, these services will be covered as described in the following sections:
□ Physician services	Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits.	Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits.
□ Diagnostic tests (like lab tests)	Please refer below to Outpatient Diagnostic	Please refer below to Outpatient Diagnostic

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	Tests and Therapeutic Services and Supplies.	Tests and Therapeutic Services and Supplies.
□ X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Surgical dressings □ Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ 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	Please refer below to Prosthetic Devices and Related Supplies.	Please refer below to Prosthetic Devices and Related Supplies.
□ 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	Please refer below to Prosthetic Devices and Related Supplies.	Please refer below to Prosthetic Devices and Related Supplies.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient Rehabilitation Services.	Please refer below to Outpatient Rehabilitation Services.
Medical Nutrition Therapy and Counseling Services This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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.		
Medicare Part B Prescription Drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: □ Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services □ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan □ Clotting factors you give yourself by injection if you have hemophilia □ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant □ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was	$0 copayment for each Medicare-covered Part B drug and non-chemotherapy drugs to treat cancer. *Your provider may need to obtain prior authorization* 5% coinsurance for each Medicare-covered chemotherapy drug to treat cancer. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$0 copayment for each Medicare-covered Part B drug and non-chemotherapy drugs to treat cancer. 5% coinsurance for each Medicare-covered chemotherapy drug to treat cancer. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
related to post-menopausal osteoporosis, and cannot self-administer the drug □ Antigens (for allergy shots) □ Certain oral anti-cancer drugs and anti-nausea drugs □ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) □ Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases □ Chemotherapy Drugs The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.medicare.uhc.com/retiree/member/documents/group-part-b-step-therapy.html You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. There may be effective, lower-cost drugs that treat the same medical condition. If you are prescribed a new Part B medication or have not recently	$0 copayment for each allergy injection and/or serum in a doctor's office. PCP or Specialist office visit copay may apply.	$0 copayment for each allergy injection and/or serum in a doctor's office. PCP or Specialist office visit copay may apply.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover the Part B drug. (For more information, see Chapter 7, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Customer Service for more information.		
Telephonic Nurse Services	Receive access to nurse consultations and additional clinical resources 24/7 at no additional cost.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Opioid Treatment Program Services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: □ U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. □ Dispensing and administration of MAT medications (if applicable) □ Substance use counseling □ Individual and group therapy □ Toxicology testing □ Intake activities □ Periodic assessments	$0 copayment for Medicare-covered opioid treatment program services. *Your provider may need to obtain prior authorization*	$0 copayment for Medicare-covered opioid treatment program services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies Covered services include, but are not limited to:		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ X-rays (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	5% coinsurance for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum.
□ X-rays when performed in a doctor's office (doctor's office visit copay will apply)	$0 copayment for each Medicare-covered standard X-ray service. *Your provider may need to obtain prior authorization*	$0 copayment for each Medicare-covered standard X-ray service.
□ Radiation (radium and isotope) therapy including technician materials and supplies (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	5% coinsurance for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Radiation (radium and isotope) therapy including technician materials and supplies performed in a doctor's office (doctor's office visit copay will apply)	$0 copayment for each Medicare-covered radiation therapy service. *Your provider may need to obtain prior authorization*	$0 copayment for each Medicare-covered radiation therapy service.
□ Surgical supplies, such as dressings □ Splints, casts, and other devices used to reduce fractures and dislocations Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	$0 copayment for each Medicare-covered medical supply. $10 copayment at a Durable Medical Equipment supplier or pharmacy for Medicare-covered medical supplies except for insulin pumps and associated supplies. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$0 copayment for each Medicare-covered medical supply. $10 copayment at a Durable Medical Equipment supplier or pharmacy for Medicare-covered medical supplies except for insulin pumps and associated supplies. You pay these amounts until you reach the out-of-pocket maximum.
□ Laboratory tests	$0 copayment for Medicare-covered lab services. *Your provider may need to obtain prior authorization*	$0 copayment for Medicare-covered lab services.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. □ In addition, for the administration of blood infusion, you will pay the cost sharing as described under the following sections of this chart, depending on where you received infusion services: o Physician/Practitioner Services, Including Doctor's Office Visits o Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers	$0 copayment for Medicare-covered blood services. *Your provider may need to obtain prior authorization*	$0 copayment for Medicare-covered blood services.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Other outpatient diagnostic tests - Non-radiological diagnostic services (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	5% coinsurance for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum.
□ Other outpatient diagnostic tests - Non-radiological diagnostic services performed in a doctor's office (doctor's office visit copay will apply)	$0 copayment for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. *Your provider may need to obtain prior authorization*	$0 copayment for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays (when the service is performed at a hospital, outpatient facility or a freestanding facility imaging or diagnostic center)	5% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization* The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).	5% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays. You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays performed in a doctor's office (doctor's office visit copay will apply).	$0 copayment for each Medicare-covered radiological diagnostic service, not including X-rays. *Your provider may need to obtain prior authorization* The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).	$0 copayment for each Medicare-covered radiological diagnostic service, not including X-rays. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient Hospital Observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7days a week.		
Outpatient Hospital Services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:		
□ Services in an emergency department	Please refer to Emergency Care.	Please refer to Emergency Care.
□ Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient Mental Health Care.	Please refer to Outpatient Mental Health Care.
□ X-rays and other radiology services billed by the hospital	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Medical supplies such as splints and casts	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
□ Certain screenings and preventive services	Please refer to the benefits preceded by the “Apple” icon.	Please refer to the benefits preceded by the “Apple” icon.
□ Certain drugs and biologicals that you can’t give yourself	Please refer to Medicare Part B Prescription Drugs.	Please refer to Medicare Part B Prescription Drugs.
□ Services performed at an outpatient clinic	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.
□ Outpatient surgery or observation	Please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.
□ Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in	Please refer to Medicare Part B Prescription Drugs and Physician/ Practitioner Services, Including Doctor’s Office	Please refer to Medicare Part B Prescription Drugs and Physician/ Practitioner Services, Including Doctor’s Office

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
"Medicare Part B Prescription Drugs" in this benefit chart.	Visits or Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers, at any location or place of service.	Visits or Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers, at any location or place of service.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.	Outpatient observation cost-sharing is explained in Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient Injectable Medications (Self-administered outpatient injectable medications not covered under Part B of Original Medicare)	Not Covered.	Not covered out-of-network.
Outpatient Mental Health Care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Please refer to virtual behavioral visits section in this chart for more information.	$10 copayment for each Medicare-covered **individual** therapy session. $10 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered **individual** therapy session. $10 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient Rehabilitation Services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$5 copayment for each Medicare-covered physical therapy and speech-language therapy visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$5 copayment for each Medicare-covered physical therapy and speech-language therapy visit. You pay these amounts until you reach the out-of-pocket maximum. $5 copayment for each Medicare-covered occupational therapy visit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	$5 copayment for each Medicare-covered occupational therapy visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization* $10 copayment for each Medicare-covered comprehensive outpatient rehabilitation facility (CORF) visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	You pay these amounts until you reach the out-of-pocket maximum. $10 copayment for each Medicare-covered comprehensive outpatient rehabilitation facility (CORF) visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient Substance Abuse Services Outpatient treatment and counseling for substance abuse.	$10 copayment for each Medicare-covered **individual** therapy session. $10 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered **individual** therapy session. $10 copayment for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers **Note**: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient,	$250 copayment for Medicare-covered surgery or other services at an outpatient hospital or ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$250 copayment for Medicare-covered surgery or services at an outpatient hospital or ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
you should ask your doctor or the hospital staff. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary. $250 copayment for Medicare-covered observation at an outpatient hospital or ambulatory surgical center. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	 $250 copayment for Medicare-covered observation at an outpatient hospital or ambulatory surgical center. You pay these amounts until you reach the out-of-pocket maximum.
Partial Hospitalization Services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	5% coinsurance each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Personal Emergency Response System (PERS) With a Personal Emergency Response System (PERS), help is a button press away. PERS is a monitoring device that can provide you with confidence, knowing you have quick access to the help 24 hours a day in any situation. The device is a lightweight, discreet button that can be worn on the wrist or as a pendant (automatic fall detection and mobile options available). The device is safe to wear in the shower or bath. You must have a working phone number, landline and/or live in an area with AT&T cellular coverage to take part in this benefit. The Lifeline cellular device works nationwide with the AT&T wireless network, but does not require you to have AT&T coverage or a cellular provider. For additional information or to order your device please call 1-855-595-0389, TTY 711, 7 a.m. - 7:30 p.m. CT, Monday - Friday & 8 a.m.– 4:30 p.m. CT Saturday or visit www.lifeline.com/uhcgroup.	$0 copayment; Benefit is available through our national provider Lifeline.	
Physician/Practitioner Services, Including Doctor's Office Visits Covered services include:		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Medically-necessary medical or surgical services furnished in a physician's office.	$5 copayment for services obtained from a primary care provider or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a primary care provider's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum.	$5 copayment for services obtained from a primary care provider or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a primary care provider's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum.
□ Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient Surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.	See "Outpatient Surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
□ Consultation, diagnosis, and treatment by a specialist.	$10 copayment for services obtained from a specialist, or under certain circumstances,	$10 copayment for services obtained from a specialist, or under certain circumstances,

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a specialist's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	treatment by a nurse practitioner or physician's assistant or other non-physician health care professionals in a specialist's office (as permitted under Medicare rules). You pay these amounts until you reach the out-of-pocket maximum.
□ Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
□ Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. □ Telehealth services for monthly end-stage renal disease-related	$5 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.	$5 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. □ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of their location. □ Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. □ Medicare-covered Remote Patient Monitoring Services □ Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient and o The check-in isn't related to an office visit in the past 7 days and o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. □ Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: o You're not a new patient and o The evaluation isn't related to an office visit in the past 7 days and o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.	*Your provider may need to obtain prior authorization*	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Consultation your doctor has with other doctors by phone, internet, or electronic health record.	$0 copayment for each Medicare-covered consultation.	$0 copayment for each Medicare-covered consultation.
□ Second opinion prior to surgery.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above). You pay these amounts until you reach the out-of-pocket maximum.
□ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). Dental services provided by a dentist in connection with care, treatment, filling, removal, or replacement of	$10 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
teeth or structures directly supporting the teeth are not Medicare-covered benefits and not covered under this benefit.		
□ Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services).	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you receive services. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit chart) depending on where you receive services. You pay these amounts until you reach the out-of-pocket maximum.
□ Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician in your home or a nursing home in which you reside.	You will pay the cost sharing that applies to primary care provider services or specialist physician services (as	You will pay the cost sharing that applies to primary care provider services or specialist physician services (as

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services. You pay these amounts until you reach the out-of-pocket maximum.
□ Certain telehealth services, including:		
○ Virtual Doctor Visits:	See “Virtual Doctor Visits” in this chart for any applicable copayments or coinsurance.	See “Virtual Doctor Visits” in this chart for any applicable copayments or coinsurance.
○ Virtual Behavioral Visits:	See “Virtual Behavioral Visits” in this chart for any applicable copayments or coinsurance.	See “Virtual Behavioral Visits” in this chart for any applicable copayments or coinsurance.
Podiatry Services Covered services include:	$10 copayment for each Medicare-covered visit in	$10 copayment for each Medicare-covered visit in

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). □ Routine foot care for members with certain medical conditions affecting the lower limbs.	an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers. You pay these amounts until you reach the out-of-pocket maximum.
Additional Routine Podiatry Treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	$10 copayment per visit for routine podiatry visits up to 6 visits per plan year.	$10 copayment per visit for routine podiatry visits up to 6 visits per plan year. Benefit is combined in and out-of-network.
Private Duty Nursing We cover medically necessary skilled nursing services provided in the hospital or in the home by a private	20% coinsurance for each visit. You pay these amounts until you reach the out-	20% coinsurance for each visit. You pay these amounts until you reach the out-

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
duty nurse who holds a valid, recognized nursing certificate and is licensed according to state law in the state where services are received. Services are covered when provided through a Medicare-certified or Accreditation Commission for Health Care (ACHC) accredited provider that can provide services safely in the home or hospital. The services requested must be ordered by a treating practitioner or specialist after a face-to-face evaluation takes place with a written treatment plan and letter of medical necessity. The face-to-face evaluation must occur no more than 90 days prior to the service request. The services requested must require the professional proficiency and skills of a registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN) due to a complex medical need and/or unstable condition. Caregiver or other appropriate support must be available to assume a portion of care. Note: Custodial and domestic services are not covered.	of-pocket maximum. There is no allowance limit per plan year for private duty nursing services. *Your provider may need to obtain prior authorization*.	of-pocket maximum. There is no allowance limit per plan year for private duty nursing services. UnitedHealthcare will only pay for private duty nursing services that are covered and medically necessary. If you are provided services that are not covered or beyond what is medically necessary you will be responsible for the additional amounts billed by the provider to you for these services. Your provider can call UnitedHealthcare prior to providing you with service to request a pre-visit coverage decision to determine if services are covered and medically necessary.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Prostate Cancer Screening Exams For men age 50 and older, covered services include the following - once every 12 months: □ Digital rectal exam □ Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart.	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic Devices and Related Supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Services" later in this section for more detail.	5% coinsurance for each Medicare-covered prosthetic device, including replacement or repairs of such devices, and related supplies. 5% coinsurance for each Medicare-covered orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	5% coinsurance for each Medicare-covered prosthetic device, including replacement or repairs of such devices, and related supplies. 5% coinsurance for each Medicare-covered orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Pulmonary Rehabilitation Services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$10 copayment for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Rally Coach Programs	$0 copayment; Start living a healthier and happier life with help from the Rally Coach programs. Through Rally Coach you have access to the following virtual coaching programs: Real Appeal®, an online weight loss program available to you as part of your health plan benefits. Real Appeal is proven to help you achieve lifelong results, one small step at a time. By providing access to tools for goal setting and progress tracking, online group sessions led by a coach, a Success Kit delivered to your door, and a community of members to keep you motivated, Real Appeal delivers the support you need to lose weight successfully. At no cost you have access to Real Appeal Weight Loss or Real Appeal Diabetes Prevention based on your unique needs.* Wellness Coaching helps you get healthy your way by providing access to digital health and wellness courses as well as personalized coaching support. - Choose health goals from sleeping better to eating smarter - Get tailored support from a coach via online chat or phone - Access self-paced courses and guided discussions 24/7 The Quit for Life® Tobacco Cessation Program gives you the support you need to quit all types of tobacco use. The program includes, but is not limited to: • One-on-one coaching sessions with a Quit Coach staff to support and guide you through the quitting process • Online Group coaching sessions • Expert-led online tobacco cessation and stress management content that provide you with additional	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	education and support between sessions available online or through the mobile app • Unlimited inbound Quit Coach support for up to one year by phone, live chat and text message • Delivery of nicotine replacement products to help you succeed Get started today at rallyhealth.com/retiree or by calling one of the following: For Real Appeal call 1-844-924-7325, TTY 711, Monday - Friday, 6 a.m. - 10 p.m. CT. For Rally Wellness Coaching call 1-800-478-1057, TTY 711, 7 a.m. - 10 p.m. CT, Monday - Thursday, 7 a.m. - 7 p.m. CT, Fridays, 8 a.m.- 4:30 p.m. CT Saturdays. For Quit for Life call 1-866-QUIT-4-LIFE, TTY 711, 24 hours a day 7 days a week. *Real Appeal Weight Loss is available to those with a BMI of 19 and higher. Real Appeal Diabetes Prevention is available to you if you have a BMI ≥ 25 (BMI ≥ 23 for Asian Americans), have Prediabetes, and no previous diagnosis of Type 1 or Type 2 Diabetes. If you are pregnant, please speak with your primary care physician before joining the program. Limitations and restrictions apply.	
Screening and Counseling to Reduce Alcohol Misuse We cover one alcohol misuse screening per year for adults with Medicare (including pregnant women)	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	counseling to reduce alcohol misuse preventive benefit.	counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive a written order for LDCT lung cancer screening, which	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		
Screening for Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
place in a primary care setting, such as a doctor's office.		
Services to Treat Kidney Disease Covered services include:		
□ Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$0 copayment for Medicare-covered benefits.	$0 copayment for Medicare-covered benefits.
□ Outpatient dialysis treatments when performed in a Medicare certified End Stage Renal Disease (ESRD) facility (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)	$10 copayment for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
□ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.	$0 copayment for Medicare-covered benefits.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.
□ Home dialysis equipment and supplies	Please refer to Durable Medical Equipment and Related Supplies.	Please refer to Durable Medical Equipment and Related Supplies.
□ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home Health Agency Care.	Please refer to Home Health Agency Care.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B Prescription Drugs.”		
Skilled Nursing Facility (SNF) Care (For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)	$0 copayment each day for Medicare-covered days 1 to 20. $50 copayment each day for Medicare-covered days 21 to 70.	$0 copayment each day for Medicare-covered days 1 to 20. $50 copayment each day for Medicare-covered days 21 to 70.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Covered services include, but are not limited to: □ Semiprivate room (or a private room if medically necessary) □ Meals, including special diets □ Skilled nursing services □ Physical therapy, occupational therapy, and speech language therapy □ Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) □ Blood - including storage and administration. Coverage begins with the first pint of blood that you need. □ Medical and surgical supplies ordinarily provided by SNFs □ Laboratory tests ordinarily provided by SNFs □ X-rays and other radiology services ordinarily provided by SNFs □ Use of appliances such as wheelchairs ordinarily provided by SNFs □ Physician/Practitioner services A 3-day prior hospital stay is not required.	$0 copayment for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization* You are covered for inpatient services in a SNF, in accordance with Medicare guidelines. Original Medicare benefit periods do not apply.	$0 copayment for additional Medicare-covered days. You pay these amounts until you reach the out-of-pocket maximum. You are covered for inpatient services in a SNF, in accordance with Medicare guidelines. Original Medicare benefit periods do not apply.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Smoking and Tobacco Use Cessation (Counseling to Stop Smoking or Tobacco Use) If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: □ Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication □ Be conducted in a hospital outpatient setting or a physician's office □ Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who	$10 copayment for each Medicare-covered supervised exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered supervised exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
are trained in exercise therapy for PAD □ Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Routine Transportation Routine transportation for up to 24 one-way trips per calendar year. Restrictions apply. □ Pick-up to or from plan approved medically related appointments (locations); limited to ground transportation only. □ Mileage reimbursement available upon request (arrangements must be set up in advance by contacting ModivCare). □ Each one-way trip must not exceed 100 miles. A trip is considered one way; a round trip is considered two trips.	$0 copayment; Benefit is available through provider Modivcare.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ The benefit cannot be used for emergency related trips. Please reach out to ModivCare for a comprehensive list of plan approved locations. □ Benefit allows up to one companion per trip at least 18 years of age or older. □ Cab/Sedan services available. □ Standard transportation services require at least 2 business days advanced notice. □ Appointments can be made up to 30 days in advance. Note: Drivers do not have medical training. In case of an emergency, call 911. Contact ModivCare for additional details and to schedule your trips: 1-833-219-1182, TTY 1-844-488-9724, 8 a.m.- 5 p.m. Monday - Friday, Local Time, or by visiting www.modivcare.com/BookNow *weekend scheduling available only for urgent requests as specified by ModivCare		
Urgently Needed Services Urgently needed services are provided to treat a non-emergency, unforeseen	$35 copayment for each visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
medical illness, injury, or condition that requires immediate medical care. Covered services include urgently needed services obtained at a retail walk-in clinic or an urgent care center. You have worldwide coverage for urgently needed services (outlined above) that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain. Services provided by a dentist are not covered. There is no additional cost share if you get multiple services in a visit.	You pay these amounts until you reach the out-of-pocket maximum.	
Virtual Behavioral Visits UnitedHealthcare's Virtual Behavioral Visits lets you choose to see and speak to a mental health professional using your computer or a mobile device, like a tablet or smart phone. This service can be used for initial evaluation, medication management and ongoing counseling. Providers can't prescribe medications in all states. You can find a list of participating virtual behavioral visit providers online at www.UHCRetiree.com/TRS-CareMA.	$10 copayment using in-network providers that have the ability and are qualified to offer virtual behavioral visits. You pay these amounts until you reach the out-of-pocket maximum.	$10 copayment using out-of-network providers that have the ability and are qualified to offer virtual behavioral visits. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Virtual Cognitive Behavioral Health Therapy	You pay $0 copayment per session. Coverage includes initial consultation and weekly therapy treatment. In-network coverage is provided by AbleTo. **AbleTo's Therapy360 Program** An 8-week therapy program which treats depression, anxiety and stress when you also have a medical condition, some examples include: - Cancer - Chronic pain - Diabetes - Heart Disease This program provides: - Private counseling sessions with a therapist and a coach via phone or secure video chat. - Personalized tips and tools to help you feel better	You pay $0 copayment per session. Coverage includes 1 initial consultation session and 8 weekly therapy treatment sessions.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	through positive thinking, behavior change, and mindfulness. □ AbleTo appointments are available 24 hours a day, 7 days a week. For more information about this program or to join, go to www.AbleTo.com/urs or call toll-free at **1-833-805-7759**. TTY users can dial **711.**	
Virtual Doctor Visits UnitedHealthcare's Virtual Doctor Visits lets you choose to see and speak to doctors using your computer or a mobile device, like a tablet or smart phone. These doctors are providers that have the ability to offer virtual doctor visits. During a virtual visit, you can ask questions, get a diagnosis and the doctor may be able to prescribe medication that, if appropriate, can be sent to your pharmacy. Doctors can't prescribe medications in all states. You can find a list of participating virtual	$0 copayment using AmWell, Doctor on Demand and Teladoc. $5 copayment using other in-network providers that have the ability and are qualified to offer virtual medical visits. You pay these amounts until you reach the out-of-pocket maximum.	$5 copayment using out-of-network providers that have the ability and are qualified to offer virtual medical visits. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
doctors online at www.UHCRetiree.com/TRS-CareMA.		
Vision Services Covered services include:		
□ Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. *Your provider may need to obtain prior authorization*	$10 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
□ 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.	$0 copayment for Medicare-covered glaucoma screening.	$0 copayment for Medicare-covered glaucoma screening.
□ For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare	$0 copayment for each Medicare-covered visit.	$0 copayment for each Medicare-covered visit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics. □ For people with diabetes, screening for diabetic retinopathy is covered once per year.	*Your provider may need to obtain prior authorization*	
□ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.	$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Routine Vision Services Please turn to Section 4 Vision Services of this chapter for more detailed information about this benefit.	**Eye Exam** $0 copayment for 1 exam every 12 months.*	**Eye Exam** $0 copayment for 1 exam every 12 months.* Benefit is combined in and out-of-network.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	Eyewear Plan pays up to $70 for eyeglasses every 24 months. Or, up to $105 for contact lenses instead of eyeglasses every 24 months.*	**Eyewear** Plan pays up to $70 for eyeglasses every 24 months. Or, up to $105 for contact lenses instead of eyeglasses every 24 months.* Benefit is combined in and out-of-network.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **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	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
know you would like to schedule your "Welcome to Medicare" preventive visit.		
Wigs Wigs will be covered for hair loss due to chemotherapy, medical treatment, or a medical condition. Includes unlimited wigs per plan year.	5% coinsurance*	

* Covered services that do not count toward your maximum out-of-pocket amount.

Section 3 What Medical services are not covered by the plan?

Section 3.1 Medical services we do not cover (exclusions)

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

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare.	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
facility, such as a telephone or a television.		
Full-time nursing care in your home.	✓	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures.		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Chiropractic Services (Medicare-covered)		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.
Routine dental care, such as cleanings, exams or x-rays.	✓	
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Home-Delivered Meals.	✓	
Orthopedic shoes.		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Supportive devices for the feet.		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture (Medicare-covered).		✓ Covered for chronic low back pain. (As specifically described in the Medical Benefits Chart in this chapter.)
Naturopath services (uses natural or alternative treatments).	✓	
All services, procedures, treatments, medications and supplies related to workers' compensation claims.	✓	
Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.	✓	
Abortion.		✓ Cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
Routine transportation.		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Health services for treatment of military service related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
pay for the services and supplies.		
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)		✓ Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	✓	
Immunizations for foreign travel purposes.	✓	
The following services and items are excluded from coverage under the transplant program:	✓ □ Transplants performed in a non-Medicare-certified transplant facility. □ Non-Medicare-covered organ transplants. □ Transplant services, including donor costs, when the transplant recipient is not a member.	✓ □ Transportation services, except as covered in accordance with Medicare guidelines. □ Food and housing costs except as covered in accordance with Medicare guidelines. □ Storage costs for any organ or bone marrow. □ Bone marrow transplants or stem cell transplantation,

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
	□ Artificial or non-human organs. □ Transportation of any potential donor for typing and matching. □ Services for which government funding or other insurance coverage is available.	except as a treatment for an appropriate diagnosis as specifically stated in the Medicare coverage guidelines or in the Evidence of Coverage.
Any non-emergency care received outside of the United States and the U.S. Territories.	✓	
For transplants: items not covered include, but are not limited to the below. For transportation: □ Vehicle rental, purchase, or maintenance/repairs □ Auto clubs (roadside assistance) □ Gas □ Travel by air or ground ambulance (may be covered under your medical benefit). □ Air or ground travel not related to medical appointments □ Parking fees incurred other than at lodging or hospital For lodging: □ Deposits □ Utilities (if billed separate from the rent payment) □ Phone calls, newspapers, movie rentals and gift cards	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
□ Expenses for lodging when staying with a relative or friend □ Meals		
In-Home Non-Medical Care		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Personal Emergency Response System (PERS)		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Real Appeal Weight Management Program		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Rally Wellness Coaching		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
Over-the-counter care FirstLine Essentials+		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)
UnitedHealthcare Healthy at Home post-discharge program		✓ (As specifically described as a covered service in the Medical Benefits Chart in this chapter.)

We regularly review new procedures, devices and drugs to determine whether or not they are safe and effective for members. New procedures and technology that are safe and effective are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safe and effective use of a new technology or new

application of an existing technology for an individual member, one of our medical directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section 4 Other additional benefits (not covered under Original Medicare)

Introduction

Your health and well-being are important to us, which is why we've developed the additional benefit(s) detailed in this section:

- Routine Hearing Services
- Routine Vision Services
- Routine Chiropractic Services

The benefit(s) described on the following pages are designed to help you stay healthy and provide well-rounded health coverage. Please read this section carefully, and reference it later if need be, to help you know what services are covered under your plan. If you ever have questions about what is covered, how to make a claim or about any other issue, please call Customer Service (phone numbers for Customer Service are on the cover of this booklet). We are always happy to provide answers to any questions you may have. We're here to serve you.

The information in this section describes the following benefits:

- Routine eye exam and routine eyewear
- Routine chiropractic care

Refer to the Routine Hearing Services benefit section below for more details on your routine hearing benefit.

These are covered health services when you follow the coverage rules in the Evidence of Coverage. These services are in addition to Medicare-covered benefits outlined in the Evidence of Coverage. The provisions of this section are incorporated into and made a part of your Evidence of Coverage. Copayments or coinsurance for these covered health services do not apply toward the annual out-of-pocket maximum (if applicable to your plan) described earlier in this chapter.

Further details on the benefits available as part of your additional benefit(s) (if applicable) are detailed in the section titled: **Covered services**.

Submit a claim or request reimbursement

When you obtain services, the service provider normally submits a claim on your behalf. If the service provider is unwilling to do so, you can ask us for reimbursement. Refer to Chapter 5 Section 2 *How to ask us to pay you back or to pay a bill you have received*.

Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.

Limitation of liability

We will not reduce or deny a claim for failure to furnish such proof within the time required, provided a claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, we will not accept a claim more than one (1) year from the date of service.

Access your benefits

You may see doctors and other health care professionals, medical groups, hospitals, and other health care facilities that are not contracted with UnitedHealthcare, as long as they accept Medicare and are willing to bill UnitedHealthcare, and as long as the services are covered benefits and are medically necessary. Unlike most PPO plans, with this plan you pay the same cost share in-network and out-of-network.

You may receive covered services from a provider anywhere in the United States by taking the following steps:

- Locate a provider of your choice.
- Call your selected provider's office to schedule your services.
- Pay the appropriate cost shares at the time of your service, if applicable.
- When you go to the provider's office for services, you may be asked to show your TRS-Care Medicare Advantage member ID card.

It is important to note that the provider has the right to decide whether or not he or she will agree to submit the bill for covered services directly to us for payment at the time he or she furnishes covered services to you. If the provider does not wish to submit the bill directly to us please follow the instructions under "Submit a Claim or Request Reimbursement".

Out-of-network benefits

You can choose to use your in-network benefits with a network provider or use your out-of-network benefits with an out-of-network provider.

Routine Hearing Services

Hearing Service Providers

You may visit any provider for your hearing exam. You may visit only a UnitedHealthcare Hearing provider for your hearing aids.

Covered services

The following services are covered under your additional hearing benefit:

Routine Hearing Exam

- You can receive a complete hearing exam, every year through any hearing service provider, including UnitedHealthcare Hearing

- No authorization needed

Please see the Medical Benefits Chart above for any copayment or coinsurance that may be due at the time of your exam.

Hearing Aids (Includes digital hearing aids)

Hearing service providers

Your health plan network hearing aid provider, UnitedHealthcare Hearing, can help get you started. You can contact UnitedHealthcare Hearing at 1-888-547-1374, TTY 711, 8 a.m. – 8 p.m. CT, Monday – Friday or by visiting www.UHCHearing.com/trs-careMA. A hearing counselor will verify eligibility and help in determining your hearing care needs. Then they will help you find a convenient location and make your appointment.

Please note:

- Hearing aid units are medical devices that fit in or near the ear.
- This benefit may cover more than one year, but it may be changed or terminated at the end of the plan year.
- There is no coverage if hearing aids or related services are received from an out-of-network provider.

Hearing aid purchase includes:

- One hearing exam for evaluation and fitting of hearing aids (combined both ears) every year
- Three hearing aid follow-up appointments within first year for in-person dispensed devices as well as those who order direct delivery through Right2You
  - Hearing aids purchased in Silver technology level receive one virtual follow-up appointment
- 45-day trial period for in-person dispensed devices and 70-day trial period for direct delivery through Right2You on home delivery devices
- Three-year extended warranty

Please see the Medical Benefits Chart above for the specific amount of your benefit as well as how often you can purchase hearing aids.

Limitations and exclusions

The limitations and exclusions below apply to your additional hearing aid benefit:

- Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered
- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs
- Covered expenses related to hearing aids are limited to plan Usual and Customary (U&C) charge of a basic hearing aid to provide functional improvement. Certain hearing aid items and

services are not covered. Items and services that are not covered include, but are not limited to, the following:

- Replacement of a hearing aid that is lost, broken or stolen if occurrence exceeds covered rate of occurrence
- Repair of the hearing aid and related services
- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes
- Coverage must be active on the date of service to utilize the benefit
- Services, accessories, or supplies that are not medically necessary according to professionally accepted standards of practice
- Replacement batteries or assistive listening devices
- The plan does not cover hearing services obtained outside of the warranty or trial period
- Services you choose to have that are not covered under the benefit will be at your own cost

Routine Vision Services

Vision Service Providers

Vision coverage is through the UnitedHealthcare Medical network. Providers should contact the provider number on the back of your TRS-Care Medicare Advantage member ID card to confirm eligibility and benefits.

You may visit any vision service provider for routine vision services.

For more information please see **Access Your Benefits** earlier in this section.

Covered services

The following services are covered under your vision benefit:

Routine Eye Exam

A routine vision exam every 12 months, through a network or out-of-network vision provider.

Routine Eyewear

The plan provides an eyewear benefit for vision correction not related to cataract surgery. Eyewear consists of frames and lenses (eyeglasses) or contact lenses.

Please refer to the Medical Benefits Chart above for details about your routine eyewear benefit.

Limitations and exclusions

The limitations and exclusions below apply to your routine vision benefit:

- Medically necessary services covered under Original Medicare.
- Government treatment for any services provided in a local, state or federal government facility or agency, except when federal or state law requires payment under the plan.

- Any treatment or services caused by or resulting from employment, or covered under any public liability insurance, including Worker's Compensation programs.
- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (non-prescription).
- 2 pair of glasses instead of bifocals.
- Subnormal (low) vision aids.
- Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- LASIK, surgeries or other laser procedures.
- Any eye exam or corrective eyewear required by an employer as a condition of employment.

Routine Chiropractic Services

Chiropractic service providers

You may visit any chiropractor for routine chiropractic services. For more information please see **Access Your Benefits** earlier in this section.

Covered services

The following services are covered under your additional chiropractic benefit:

- A maximum number of visits per year, including evaluation of X-rays.
- An initial exam with a chiropractor to determine the nature of your problem and prepare a treatment plan if necessary.
- Follow-up visits to chiropractors, as indicated by a treatment plan, which may include spinal manipulations, therapy, and X-ray procedures with the exception of those listed in the limitations and exclusions, and extraspinal manipulation when medically necessary.
- Any of the following when medically necessary: radiology codes for the spine, traction, whirlpool, manual electrical stimulation, ultrasound, therapeutic exercise, neuromuscular reeducation, massage when performed by a chiropractor, attended therapy techniques, dynamic therapeutic activities, spinal manipulation, and extraspinal manipulation.
- A re-evaluation to assess the need to continue, extend or change your treatment plan. If a separate appointment is made to re-evaluate your treatment plan, it will count as a visit and a copayment or coinsurance will be required.
- X-rays and laboratory tests are covered in full when prescribed by a chiropractor for medically necessary services. X-ray interpretations or consultations are only covered when performed by a chiropractor or an American Radiology Association (ARA) radiologist.

Please refer to the Medical Benefits Chart above for your copayment or coinsurance and the number of visits allowed under this plan.

Limitations and exclusions

The limitations and exclusions below apply to your additional chiropractic benefit:

- Government treatment for any services provided in a local, state or federal government facility or agency, except when federal or state law requires payment under the plan.
- Any treatment or services caused by or resulting from employment, or covered under any public liability insurance, including Worker's Compensation programs.
- Terms and conditions of coverage not outlined in the Evidence of Coverage.
- Any accommodation, service, supply or other item determined not to be medically necessary, except for routine covered chiropractic services.
- Services for an exam or treatment of strictly non-neuromuscular-skeletal disorders.
- Services that are not documented as necessary and appropriate, or are experimental or investigational chiropractic care.
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning.
- Any services or treatment for Temporomandibular Joint Disease (TMJ). TMJ is a condition of the jaw joint that commonly causes headaches, tenderness of the jaw muscles or dull aching facial pain.
- Treatment or service for pre-employment physicals or vocational rehabilitation.
- Thermography.
- Hypnotherapy, behavior training, sleep therapy, weight programs, educational programs, non-medical self-care or self-help including any self-help physical exercise training, or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic mattress supplies or any other similar devices or appliances.
- Vitamins, minerals, nutritional supplements or other similar-type products.
- Manipulation under anesthesia, hospitalization or any related services.
- Prescription drugs or medicines, including non-legend or proprietary medicine, that don't require a prescription order.
- Measurement codes, transcutaneous electrical nerve stimulator (TENS) unit for chronic low back pain and related supplies, assistant at surgery, unattended electrical stimulation, gait training, osteopathic manipulation, foot orthotics, X-rays other than for the spine, infrared and ultraviolet therapy, vertebral axial decompression, and massage not performed by a chiropractor.

Chapter 5

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

Chapter 5

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

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

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

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

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

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

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

When you received services from a provider in the United States who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.
- You can also receive emergency or urgently needed services from a provider outside the United States. If you receive emergency or urgently-needed services outside of the United States, the provider may require that you pay for the cost of the services in full. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to

assist us in obtaining all of the information necessary to properly process your request for reimbursement, including medical records.

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow network providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.4.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the cover of this booklet.)

4. When you utilize your Worldwide Emergency Coverage, Worldwide Urgently Needed Services, or Worldwide Emergency Transportation benefits

You will pay the full cost of emergency services received outside of the United States at the time you receive services. To receive reimbursement from us, you must do the following:

- Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 of this document.
- Save all of your receipts and send us copies when you ask us to pay you back. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost. Please see Chapter 5 Section 2.1 for expense reimbursement for worldwide services.

- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to help coordinate payment for covered services on your behalf.

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

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

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

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

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

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

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

Medical Claims payment requests
UnitedHealthcare
P.O. Box 30995
Salt Lake City, UT 84130-0995

You must submit your Part C (medical) claim to us within 12 months of the date you received the service, item, or Part B drug.

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

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail

your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

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

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))**. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

Chapter 6

Your rights and responsibilities

Chapter 6
Your rights and responsibilities

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

Section 1.1 You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the cover of this booklet).

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

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

You also have the right to choose an out-of-network provider that participates in Medicare. Call the Customer Service number listed on the cover of this booklet for more information.

As a plan member, you have the right to get appointments and covered services from your providers, **within a reasonable amount of time**. This includes the right to get timely services from specialists when you need that care.

How to Receive Care After Hours

If you need to talk to or see your Primary Care Provider after the office has closed for the day, call your Primary Care Provider's office. When the on-call physician returns your call he or she will advise you on how to proceed. Because you are a member of the TRS-Care Medicare Advantage plan, you can see any provider (network or out-of-network) at the same cost share, as long as they accept Medicare and are willing to bill UnitedHealthcare.

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

Section 1.3 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.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

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

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

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Medical Information Privacy Notice

Effective January 1, 2022

We[1] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give

out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice.

We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, www.UHCRetiree.com/TRS-CareMA. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

 To Provide You Information on Health-Related Programs or Products such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

 For Plan Sponsors. If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

 For Underwriting Purposes. We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

 For Reminders. We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

 For Communications to You. We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

 As Required by Law. We may disclose information when required to do so by law.

 To Persons Involved with Your Care. We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and as permitted by federal law.

- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your TRS-Care Medicare Advantage member ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website, **www.UHCRetiree.com/TRS-CareMA**.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your TRS-Care Medicare Advantage member ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-347-9507 (TTY/RTT 711).**
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare Privacy Office
  PO Box 1459
  Minneapolis, MN 55440

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

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[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MD – Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; Symphonix Health Insurance, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of

Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2022

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, “personal financial information” means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;

- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your TRS-Care Medicare Advantage member ID card or contact the UnitedHealth Group Customer Call Center at 1-866-347-9507 (TTY/RTT 711)**.

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[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on page four of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc.; Genoa Healthcare, LLC; Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; ;United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how UnitedHealthcare plans compare to other Medicare health plans.
- **Information about our network providers**.
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the **Provider Directory**.
  - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the cover of this booklet) or visit our website at www.UHCRetiree.com/TRS-CareMA.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.

Section 1.6 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made

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

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

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

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

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

Is it about something else?

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

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

Section 1.8 You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on the cover of this booklet).
- For information on the quality program for your specific health plan, call the Customer Service number on the cover of this booklet. You may also access this information via the website (https://www.uhcmedicaresolutions.com/resources/ma-pdp-information-forms.html). Select, "Commitment to Quality."
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.

- Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your TRS-Care Medicare Advantage member ID card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members (or TRS on your behalf) must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - You risk losing all TRS-Care coverage if you do not have Medicare Part B.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call TRS Health & Insurance Benefits Department at 1-888-237-6762 (TTY: 711), 7 a.m. – 6 p.m., CT Monday – Friday.

- **If you move outside of our plan service area, you cannot remain a member of our plan**. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
- **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **If** you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

 Call Customer Service for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.

- Phone numbers and calling hours for Customer Service are printed on the cover of this booklet.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7

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

Chapter 7

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

Coverage decisions and appeals

Making complaints

Section 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

Section 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at

this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

Coverage decisions and appeals

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

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

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

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

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

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

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"

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

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: **Medical Benefits Chart (what is covered and what you pay)**. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

- NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
  - Chapter 7, Section 6: **How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.**
  - Chapter 7, Section 7: **How to ask us to keep covering certain medical services if you think your coverage is ending too soon.** This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For **all other** situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

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

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

Legal Terms: When a coverage decision involves your medical care, it is called an **"organization determination."**

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

Legal Terms: A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request for a medical item or service. If your request is **for a Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

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

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

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request **for a medical item or service, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - **If** you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision **only** if you are asking for coverage for medical care **you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)

- You can get a fast coverage decision **only** if using the standard deadlines could **cause serious harm to your health or hurt your ability to function.**

- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If** you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

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

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for

a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.

- For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms: An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, **How to contact us when you are making an appeal about your medical care**.

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

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

Legal Terms: A "fast appeal" is also called an **"expedited reconsideration."**

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

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

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

Deadlines for a "fast" appeal

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

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your **health** condition requires us to.
  - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we

are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Legal Terms: The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

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

- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the

provider. (When we send the payment, it's the same as saying **yes** to your request for a coverage decision.)

- If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying **no** to your request for a coverage decision.)

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

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

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

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

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

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

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

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

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

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must

give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

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

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2, of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly:

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

Ask for a "fast review":

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

> **Legal Terms:** A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

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

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

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

What happens if the answer is yes?

- If the review organization says **yes** to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

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

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

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

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

Legal Terms: A "fast" review (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact our plan and ask for a "fast review."

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

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

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

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

- If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If our plan says no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

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

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms: The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as

long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

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

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

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

This section is about the following types of care **only**:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, **Definitions of important words**.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, **Definitions of important words**.)

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

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

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

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

> **Legal Terms:** In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.) The written notice is called the **"Notice of Medicare Non-Coverage."**

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

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date on the Notice of Medicare Non-Coverage.**
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

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

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms: This notice of explanation is called the **"Detailed Explanation of Non-Coverage."**

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say **no** to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

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

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your

Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms: A "fast" review (or "fast appeal") is also called an **"expedited appeal."**

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms: The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

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

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

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

Section 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

Level 4 Appeal: The 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** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might 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. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

Making complaints

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

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

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

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

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

Complaint	Example
Quality of your medical care	- Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	- Has someone been rude or disrespectful to you? - Are you unhappy with how our Customer Service has treated you? - Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	□ Are you having trouble getting an appointment, or waiting too long to get it? □ Have you been kept waiting too long by doctors or other health professionals? Or by Customer Service or other staff at our plan? ° Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	□ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	□ Do you believe we have not given you a notice that we are required to give? □ Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: □ If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. □ If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. □ When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. □ When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. 1-866-347-9507, TTY: 711, 7 a.m. - 6 p.m. CT, Monday - Friday
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible as but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

  If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care."

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

Legal Terms: What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

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

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

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

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

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

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about TRS-Care Medicare Advantage directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare

takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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

Chapter 8

Ending your membership in the plan

Chapter 8
Ending your membership in the plan

Section 1 Introduction

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

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you **want** to leave.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

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

If you drop TRS-Care coverage, you cannot re-enroll in the program unless you experience a Special Enrollment Opportunity such as a marriage. Contact TRS Health & Insurance Benefits for information about disenrolling from TRS-Care Medicare Advantage PPO.

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

You may end your membership in TRS-Care Medicare Advantage PPO at any time. If you drop TRS-Care coverage, you cannot re-enroll in the program unless you experience a Special Enrollment Opportunity such as a marriage. Contact TRS Health & Insurance Benefits for information about disenrolling from TRS-Care Medicare Advantage PPO.

Section 2.1 Where can you get more information about when you can end your membership?

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

- Call TRS
- You can **call Customer Service** (phone numbers are printed on the cover of this booklet).
- You can find the information in the **Medicare & You 2022** Handbook.
  - Everyone with Medicare receives a copy of the **Medicare & You 2022** handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 3 Until your membership ends, you must keep getting your medical services through our plan

Section 3.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your medical care through our plan.

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

Section 4 We must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- We are notified that you no longer meet the eligibility requirements of TRS.
- TRS' contract with us is terminated.
- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than 6 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's service area. (Phone numbers are printed on the cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your TRS-Care Medicare Advantage member ID card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

Section 4.2 We cannot ask you to leave our plan for any reason related to your health.

Our plan is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

Section 4.3 You have the right to make a complaint if we end your membership in our plan

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

Chapter 9
Legal notices

Chapter 9
Legal notices

Section 1 Notice about governing law

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

Section 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service 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, our plan, 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 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we

shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1) **Our payments are less than the recovery amount**. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a) **First**: Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b) **Second**: Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c) **Third**: Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2) **Our payments equal or exceed the recovery amount**. If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a) Our payments made on your behalf for services; or
   b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section 5 Member liability

Note: This section only applies to you if you are required by your plan rules to obtain a referral before seeing non-network providers. Please see the chapter entitled **Using the plan's coverage for your medical services** to see if your plan requires referrals to non-network providers.

You will be liable if you receive services from non-network providers without authorization or a referral.

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services except for the following eligible expenses:

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a provider, neither the plan nor Medicare will pay for those services.

Section 6 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  2. Furnished in a setting appropriate to the patient's medical needs and condition;
  3. Ordered and furnished by qualified personnel;
  4. One that meets, but does not exceed, the patient's medical need; and
  5. At least as beneficial as an existing and available medically appropriate alternative.

Section 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership**.

Section 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered

services insofar as practical and according to our best judgment. Neither we nor any provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section 9 Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare Insurance Company or one of its affiliates. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

Section 10 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section 11 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

Section 12 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals

- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section 13 2022 Enrollee Fraud & Abuse Communication

2022 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.

Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person's Medicare card to get medical care, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call TRS-Care Medicare Advantage Customer Service at 1-866-347-9507 (TTY 711), 7 a.m. - 6 p.m. CT, Monday - Friday.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is www.medicare.gov.

Section 14 Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Chapter 10

Definitions of important words

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

Annual Enrollment Period (Medicare) – A set time each fall when members can change their health or drug plans or switch to Original Medicare. Please contact TRS for more information or visit https://www.trs.texas.gov/Pages/healthcare_trscare_eligibility.aspx for details about TRS-Care eligibility and enrollment.

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

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

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost-sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

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

Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all services from both network providers and out-of-network providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

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

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, or hospital outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

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

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

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

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

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

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly

getting worse.

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

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

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

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by Medicare or the plan.

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

Initial Enrollment Period (Medicare) – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare

when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65. Please contact TRS for more information or visit https://www.trs.texas.gov/Pages/healthcare_trscare_eligibility.aspx for details about TRS-Care eligibility and enrollment.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered services received from in-network providers. After you have reached this limit, you will not 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 provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Programs of All-inclusive Care for the Elderly (PACE) plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. TRS-Care Medicare Advantage does not offer Medicare prescription drug coverage. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services. For covered out-of-network services, it can save you money if your doctor or supplier accepts assignment. If a doctor or supplier accepts assignment, your cost-sharing is limited to your copayment or coinsurance amount for the covered service.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with

Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

"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).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Provider – "Provider" is the general term we use 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. We call them "**network providers**" when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage Plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan 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 provider (network or out-of-network) at the same cost share, as long as they accept Medicare and are willing to bill UnitedHealthcare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social,

and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the cover of this booklet).

Part C – see **"Medicare Advantage (MA) Plan."**

Plan Sponsor – Teacher Retirement System of Texas (TRS).

Plan Year – The period of time TRS has contracted with us to provide covered services to you through the plan. TRS' plan year is listed inside the front cover of the Evidence of Coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from in-network or out-of-network providers.

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

Prior Authorization – For medical services it means a process where your PCP or treating provider must receive approval in advance before certain medical services will be provided or payable. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. In the network portion of a PPO, some in-network medical services are covered only if your PCP or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Providers – Doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

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

Special Enrollment Period (Medicare) – 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 into a nursing home, or if we violate our contract with you. Please contact TRS for more information or visit https://www.trs.texas.gov/Pages/healthcare_trscare_eligibility.aspx for details about TRS-Care eligibility and enrollment.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

TRS-Care Medicare Advantage Customer Service:

Call **1-866-347-9507**

Calls to this number are free. 7 a.m. - 6 p.m. CT, Monday - Friday. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 7 a.m. - 6 p.m. CT, Monday - Friday.

Write: **P.O. Box 30769**
Salt Lake City, UT 84130-0769

www.UHCRetiree.com/TRS-CareMA

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

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