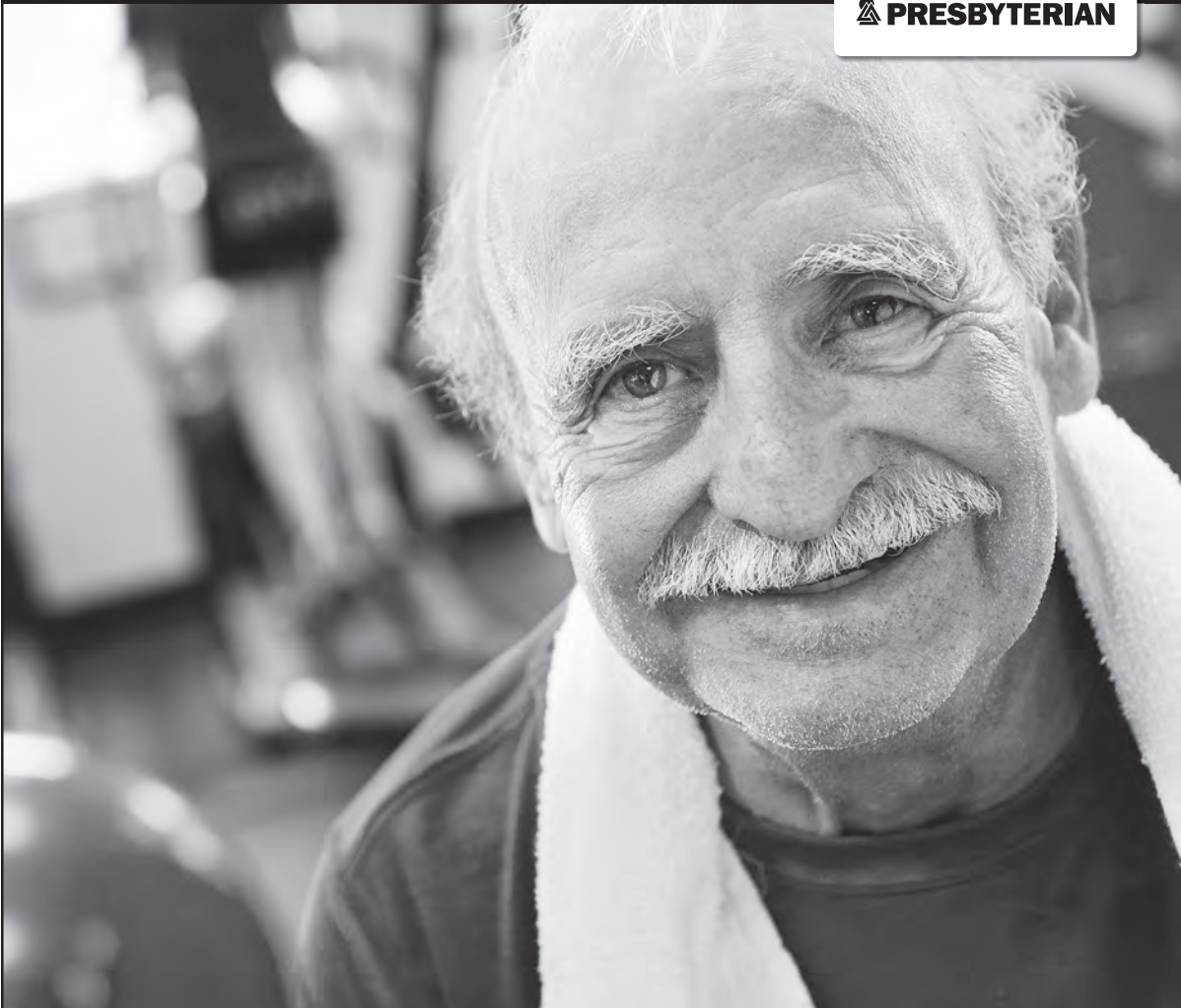


January 1 - December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services
as a Member of Presbyterian Senior Care Plan 1 (HMO)

 **PRESBYTERIAN**



January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Presbyterian Senior Care Plan 1 (HMO)

This document gives you the details about your Medicare health care coverage from January 1-December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact our Presbyterian Customer Service Center (customer service) at (505) 923-6060 or 1-800-797-5343. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., seven days a week (except holidays) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

This plan, Presbyterian Senior Care Plan 1 (HMO), is offered by Presbyterian Health Plan, Inc. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Presbyterian Health Plan, Inc. When it says “plan” or “our plan,” it means Presbyterian Senior Care Plan 1 (HMO).)

Presbyterian Senior Care (HMO) is a Medicare Advantage plan with a Medicare contract. Enrollment in Presbyterian Senior Care (HMO) depends on contract renewal.

This document is available for free in Spanish.

Customer service has free language interpreter services available for non-English speakers.

This information is available in other formats. Contact customer service for more information.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

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

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

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

Table of Contents**2023 Evidence of Coverage****Table of Contents**

CHAPTER 1: <i>Getting started as a member</i>	4
SECTION 1 Introduction.....	5
SECTION 2 What makes you eligible to be a plan member?	6
SECTION 3 Important membership materials you will receive.....	7
SECTION 4 Your monthly costs for Presbyterian Senior Care Plan 1 (HMO)	8
SECTION 5 Keeping your plan membership record up to date	9
SECTION 6 How other insurance works with our plan	10
CHAPTER 2: <i>Important phone numbers and resources</i>	12
SECTION 1 Presbyterian Senior Care Plan 1 (HMO) contacts (how to contact us, including how to reach customer service).....	13
SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program).....	15
SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	16
SECTION 4 Quality Improvement Organization	17
SECTION 5 Social Security	18
SECTION 6 Centennial Care (Medicaid).....	19
SECTION 7 How to contact the Railroad Retirement Board.....	20
SECTION 8 Do you have “group insurance” or other health insurance from an employer?	21
CHAPTER 3: <i>Using the plan for your medical services</i>	22
SECTION 1 Things to know about getting your medical care as a member of our plan	23
SECTION 2 Use providers in the plan’s network to get your medical care.....	25
SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster	29
SECTION 4 What if you are billed directly for the full cost of your services?	32
SECTION 5 How are your medical services covered when you are in a “clinical research study”?	32
SECTION 6 Rules for getting care in a “religious non-medical health care institution”	34
SECTION 7 Rules for ownership of durable medical equipment	35
CHAPTER 4: <i>Medical Benefits Chart (what is covered and what you pay</i>	37
SECTION 1 Understanding your out-of-pocket costs for covered services.....	38

Table of Contents

SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered and how much you will pay.....	39
SECTION 3	What services are not covered by the plan?	93
CHAPTER 5: Asking us to pay our share of a bill you have received for covered medical services		102
SECTION 1	Situations in which you should ask us to pay our share of the cost of your covered services	103
SECTION 2	How to ask us to pay you back or to pay a bill you have received	104
SECTION 3	We will consider your request for payment and say yes or no	105
CHAPTER 6: Your rights and responsibilities		106
SECTION 1	Our plan must honor your rights and cultural sensitivities as a member of the plan.....	107
SECTION 2	You have some responsibilities as a member of the plan	113
CHAPTER 7: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)		115
SECTION 1	Introduction.....	116
SECTION 2	Where to get more information and personalized assistance.....	116
SECTION 3	To deal with your problem, which process should you use?	117
SECTION 4	A guide to the basics of coverage decisions and appeals.....	118
SECTION 5	Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision.....	120
SECTION 6	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.....	128
SECTION 7	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	135
SECTION 8	Taking your appeal to Level 3 and beyond.....	141
SECTION 9	How to make a complaint about quality of care, waiting times, customer service, or other concerns	143
CHAPTER 8: Ending your membership in the plan.....		147
SECTION 1	Introduction to ending your membership in our plan	148
SECTION 2	When can you end your membership in our plan?	148
SECTION 3	How do you end your membership in our plan?.....	150
SECTION 4	Until your membership ends, you must keep getting your medical services through our plan.....	151
SECTION 5	Presbyterian Senior Care Plan 1 (HMO) must end your membership in the plan in certain situations	151

Table of Contents

CHAPTER 9: <i>Legal notices</i>	153
SECTION 1 Notice about governing law	154
SECTION 2 Notice about non-discrimination.....	154
SECTION 3 Notice about Medicare Secondary Payer subrogation rights	154
CHAPTER 10: <i>Definitions of important words</i>	155

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1	You are enrolled in Presbyterian Senior Care Plan 1 (HMO), which is a Medicare HMO
--------------------	---

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Presbyterian Senior Care Plan 1 (HMO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Presbyterian Senior Care Plan 1 (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Presbyterian Senior Care Plan 1 (HMO) does not include Part D prescription drug coverage.

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

Section 1.2	What is the <i>Evidence of Coverage</i> document about?
--------------------	--

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

The words “coverage” and “covered services” refers to the medical care and services available to you as a member of Presbyterian Senior Care Plan 1 (HMO).

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

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

Section 1.3	Legal information about the <i>Evidence of Coverage</i>
--------------------	--

This *Evidence of Coverage* is part of our contract with you about how Presbyterian Senior Care Plan 1 (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Presbyterian Senior Care Plan 1 (HMO) between January 1, 2023 and December 31, 2023.

Chapter 1 Getting started as a member

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Presbyterian Senior Care Plan 1 (HMO) after December 31, 2023. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve Presbyterian Senior Care Plan 1 (HMO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

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

Section 2.2 Here is the plan service area for Presbyterian Senior Care Plan 1 (HMO)

Presbyterian Senior Care Plan 1 (HMO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New Mexico: Bernalillo, Cibola, Rio Arriba, Sandoval, Santa Fe, Socorro, Torrance, and Valencia.

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

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

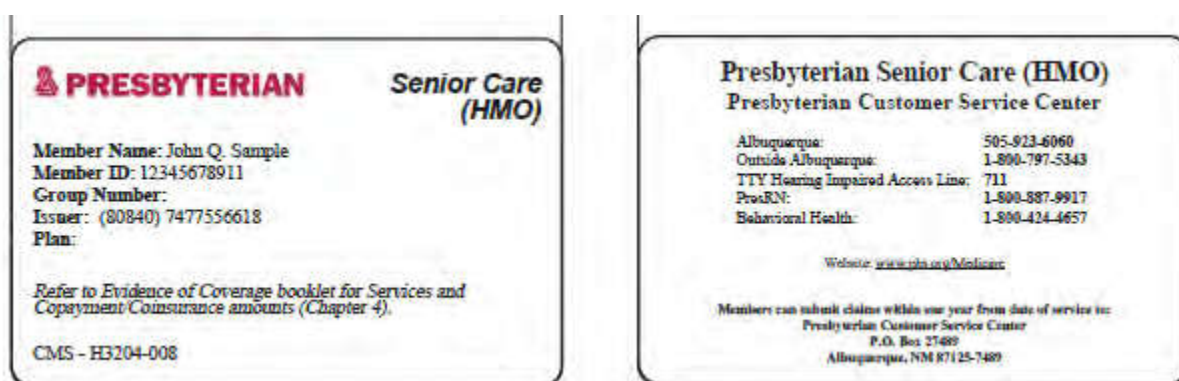
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Presbyterian Senior Care Plan 1 (HMO) if you are not eligible to remain a member on this basis. Presbyterian Senior Care Plan 1 (HMO) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Presbyterian Senior Care Plan 1 (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider Directory

The *Provider Directory* lists our network providers. **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 any plan cost sharing as payment in full.

Chapter 1 Getting started as a member

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Presbyterian Senior Care Plan 1 (HMO) authorizes use of out-of-network providers.

If you don't have your copy of the *Provider Directory*, you can request a copy from customer services.

SECTION 4 Your monthly costs for Presbyterian Senior Care Plan 1 (HMO)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2023 handbook, the section called “2023 Medicare Costs.” If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan Premium

You do not pay a separate monthly plan premium for Presbyterian Senior Care Plan 1 (HMO).

Section 4.2 Monthly Medicare Part B Premium
--

Many members are required to pay other Medicare premiums

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

Section 4.3 Optional Supplemental Benefit Premium
--

If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

The Comprehensive Dental Plan is in addition to the Basic Dental Plan in which you will automatically be enrolled. If you want these optional supplemental dental benefits, you must sign up for them and pay an additional premium of \$9 per month.

Section 4.4 Can we change your monthly plan premium during the year?

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

SECTION 5 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling customer service.

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

SECTION 6 How other insurance works with our plan

Other Insurance

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

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

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

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

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

Chapter 1 Getting started as a member

- Workers' compensation

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

CHAPTER 2:

*Important phone numbers
and resources*

SECTION 1 Presbyterian Senior Care Plan 1 (HMO) contacts (how to contact us, including how to reach customer service)

How to contact our plan's customer service

For assistance with claims, billing, or member card questions, please call or write to Presbyterian Senior Care Plan 1 (HMO) customer service. We will be happy to help you.

Method	Presbyterian Customer Service Center – Contact Information
CALL	<p>(505) 923-6060 or 1-800-797-5343</p> <p>Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week (except holidays) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.</p> <p>After hours, an automated voice messaging service is available. If you leave a message, please include your name, phone number and the time you called. A customer service representative will return your call no later than one business day after you leave your message.</p> <p>Customer service also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Hours are 8 a.m. to 8 p.m., seven days a week (except holidays) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.</p>
FAX	(505) 923-5124

Method	Presbyterian Customer Service Center – Contact Information
WRITE	<p>General Inquiries and Payment Information: Presbyterian Senior Care (HMO) P.O. Box 27489 Albuquerque, NM 87125-7489</p> <p>Appeals, Grievances, and Complaints: Presbyterian Senior Care (HMO) Attn: Appeals and Grievances Department P.O. Box 27489 Albuquerque, NM 87125-7489 Email: gappeals@phs.org</p> <p>Please include your first and last name, date of birth, a contact address and phone numbers, and the details of your inquiry. Presbyterian members should also include their member identification number, if available.</p> <p>Palliative Care and Hospice Program: Presbyterian Health Plan Care Coordination Department (505) 923-8858 or 1-866-672-1242 (TTY only, call 711)</p>
WEBSITE	<p>www.phs.org/Medicare</p> <p>You can send an inquiry to the customer service by visiting the Contact Us link on our website.</p>

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

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

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

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

Chapter 2 Important phone numbers and resources

You can submit a complaint about Presbyterian Senior Care Plan 1 (HMO) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

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 documents you can print

Chapter 2 Important phone numbers and resources

Method	Medicare – Contact Information
	<p>directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about Presbyterian Senior Care Plan 1 (HMO):</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about Presbyterian Senior Care Plan 1 (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New Mexico, the SHIP is called New Mexico Aging and Long-Term Services.

New Mexico Aging and Long-Term Services is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Chapter 2 Important phone numbers and resources

New Mexico Aging and Long-Term Services counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. New Mexico Aging and Long-Term Services counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

Method to Access SHIP and Other Resources

- Visit www.medicare.gov
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: 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.

Method	New Mexico Aging and Long-Term Services Contact Information
CALL	1-800-432-2080; calls to this number are free.
TTY	(505) 476-4937; calls to this number are not free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New Mexico Aging and Long-Term Services P.O. Box 27118 Santa Fe, NM 87502-7118
WEBSITE	www.nmaging.state.nm.us/

SECTION 4 Quality Improvement Organization

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

Chapter 2 Important phone numbers and resources

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

You should contact KEPRO 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, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	KEPRO (New Mexico's Quality Improvement Organization) Contact Information
CALL	1-888-315-0636; calls to this number are free.
TTY	711; calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5201 W. Kennedy Blvd.; Suite 900 Tampa, FL 33609
WEBSITE	www.keproqio.com

SECTION 5 Social Security

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

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

Chapter 2 Important phone numbers and resources

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

SECTION 6 Centennial Care (Medicaid)

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayment amounts. You pay nothing, except for Part D prescription drug copays.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB +):** Medicaid pays your Part B premium and provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you must pay cost-sharing when a service or benefit is not covered by Medicaid.
- **Qualifying Individual (QI):** Helps pay Part B premiums

Chapter 2 Important phone numbers and resources

- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost-sharing when a service or benefit is not covered by Medicaid.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and its programs, contact the New Mexico Human Services Department.

Method	New Mexico Human Services Department Medical Assistance Division (Centennial Care/Medicaid program) – Contact Information
CALL	1-800-283-4465; calls to this number are free.
TTY	711; calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New Mexico Human Services Department Medical Assistance Division (Centennial Care/Medicaid) P.O. Box 2348 Santa Fe, NM 87505-2384
WEBSITE	www.hsd.state.nm.us

SECTION 7 How to contact the Railroad Retirement Board

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

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

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

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or 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. (Phone numbers for customer service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

*Using the plan
for your medical services*

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

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

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

Section 1.1 What are “network providers” and “covered services”?
--

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

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

As a Medicare health plan, Presbyterian Senior Care Plan 1 (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Presbyterian Senior Care Plan 1 (HMO) will generally cover your medical care as long as:

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

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

- In most situations, Presbyterian Senior Care Plan 1 (HMO) must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies." For more information about this, see Section 2.3 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Prior authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

A primary care provider (PCP) is your main health care provider in non-emergency situations. As a member, you may choose any available network provider to be your PCP. As we explain below, you will get your routine and basic care from your PCP, and he or she is the first person you should call when you need medical care, except in an emergency or urgent care situation.

- **What types of providers may act as a PCP?**

Your PCP is a physician, nurse practitioner, or other health professional that meets state requirements and is trained to give your primary medical care.

- **What is the PCP's role?**

Your PCP's role is to:

- Provide preventive care and teach healthy lifestyle choices
- Identify and treat common medical conditions
- Assess the urgency of your medical problems and direct you to the best place for care
- Assist you in finding a medical specialist when necessary

Since your PCP will provide and coordinate your medical care, you should have all your past medical records sent to your PCP's office.

Certain services require prior authorization (PA). Your PCP will coordinate access for those services that he or she determines you may need. Please see the Benefits Chart in Chapter 4, Section 2 for information about what services require prior authorization or contact customer service.

How do you choose your PCP?

You will be asked to select a PCP at the time of enrolling in our plan. You may select a PCP from any of our available plan practitioners or providers. If there is a particular specialist or hospital facility that you want to use, check first to be sure that your PCP coordinates care with that specialist or hospital.

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

We recommend you choose a PCP close to your home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship with your PCP that much easier.

Our plan's Provider Directory provides a complete list of network practitioners and providers. If you need help choosing or changing your PCP, please contact customer service.

If you cannot find your current practitioner in this directory and would like to confirm that your doctor is in our plan, please contact customer.

If you are selecting a new PCP and would like to know if the PCP is accepting new patients, please contact customer service.

You can also email customer service at info@phs.org. Our listing of providers may change from time to time, and our representatives have the most up-to-date information available for you. You may also visit our website at www.phs.org/Medicare (select Providers, then select plan).

If you choose a PCP that you have not seen before, we suggest you do the following:

- Call your PCP's office as soon as possible and tell the staff you are a new member of our plan.
- Make an appointment to see your PCP so he or she can get to know you and begin taking care of your medical needs. You do not have to wait until you are sick to make this appointment. You should get to know your PCP as soon as possible.
- Ask your previous doctor to send your medical records to your new PCP.

Changing your PCP

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

Your request may be in writing, telephone, sending an email to info@phs.org, or by signing in to your myPRES account at www.phs.org/Medicare. PCP changes take effect on the next business day after your request. Customer service will check to make sure the network PCP you selected is accepting new patients.

Our goal is to make your transition to a new PCP as seamless as possible, with no interruption to your care. As always, if you have an urgent or emergent medical need, we encourage you to seek care at an appropriate urgent care or emergency facility.

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

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call customer service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- To obtain care after normal office hours, call 911 in an emergency, or for medical advice, call PresRN at 1-800-887-9917

Customer service is here to answer your questions. Presbyterian Senior Care (HMO) members may call (505) 923-6060 or 1-800-797-5343 (TTY 711). Hours are 8 a.m. to 8 p.m., seven days a week (except holidays) from **October 1 through March 31**, and Monday to Friday (except holidays) from **April 1 through September 30**.

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

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.
- Palliative care and hospice providers for patients who need comfort care.

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan.

- Referrals are not required by Presbyterian Senior Care (HMO); however, some providers may request a referral.
- In-network providers and practitioners are required to assist our members in obtaining prior authorization.
- For some types of services and care, your provider may need to get approval in advance from our plan (this is called getting "prior authorization"). Services that need prior

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

authorization are identified by statements in bold in the Medical Benefits Chart in Chapter 4, Section 2.1.

- You are responsible for making sure that your provider has obtained prior authorization from the plan before you receive care or services that require it.
- If you need transitional/concurrent care when you elect hospice, your hospice provider will develop and submit a care plan to us with the services you need. While this is not a prior authorization, without a care plan we cannot pay for these additional services. See Hospice Care in the Medical Benefits Chart in Chapter 4, Section 2.1.

You can access a list of our plan providers on our website at www.phs.org/Medicare, or call customer service. Customer service is available to help you locate a specialist or provider.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization should be obtained from the plan prior to seeking care.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan or both. Please see Chapter 7.

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

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor Original Medicare will pay for these services except for the situations listed below.

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

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergent or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Chapter 3, Section 3.
- If our plan authorizes the use of an out-of-network provider:
 - If our plan authorizes the use of an out-of-network provider who accepts Medicare assignment, the provider has agreed to accept your cost-sharing and the amount paid by Presbyterian as payment in full.
 - When you are outside of our service area, should you opt to see a provider who does not participate with Medicare, the provider may charge you more for services you receive. Our plan is not obligated to find a participating Medicare provider for you and we will not pay the extra amount that the out-of-network provider charges you.
- If you need a type of service that cannot be provided by an in-network provider, you must obtain prior authorization before getting the service.
- Your PCP or in-network specialist or other provider will need to contact our plan to obtain prior authorization.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.

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

Section 3.1 Getting care if you have a medical emergency
--

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or

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

its territories, and from any provider with an appropriate state license even if they are not part of our network.

- Our plan covers worldwide emergency and urgent care services if you receive care outside the United States.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please contact customer service at (505) 923-6060 or 1-800-797-5343 (TTY 711).

What is covered if you have a medical emergency?

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

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

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

What if it wasn't a medical emergency?

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

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

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

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

What are “urgently needed services”?

An “urgently needed service” is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed

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

services may be furnished by out-of-network providers when it is unreasonable, given your circumstances, to obtain immediate care from network providers.

We know that sometimes it is difficult to know what type of care you need. Presbyterian Health Plan members have access to PresRN, a nurse advice line available to you 24 hours a day, 7 days a week, including holidays. There is no charge to call our experienced registered nurses (RNs) for answers to your questions and health concerns. As always, if you are having a medical emergency, please call 911.

PresRN is an easy way to speak with a Presbyterian nurse if you are not feeling well and do not know what to do. Just call (505) 923-5573 or 1-800-887-9917 and one of our qualified nurses will listen to your health concerns and give you the answers that you need to care for you and your family. Our Presbyterian nurses are happy to answer general health questions when you are healthy, too. Our nurses assess your symptoms using nationally recognized protocols. Whether your situation requires a trip to the emergency room or self-care at home, you will know what to do. Our nurses will guide you to the most appropriate care option, including:

- Nurse or physician advice (24 hours a day, 7 days a week)
- A scheduled physician telephone visit (also assists you in using Video Visits)
- An urgent care visit (urgent care copayment applies)
- An emergency visit (emergency copayment applies)

As part of your Presbyterian health care team, we let your doctor, care coordinator and health coach know of your health concern so that you will have continued care and follow up. Most importantly – we are here when you need answers.

If an urgent situation occurs, you should go directly to the nearest urgent care center for treatment. We will cover the service in accordance with your benefit. You should contact your PCP following any urgent care visits.

Our plan covers worldwide emergency and urgent care services if you receive care outside the United States.

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.phs.org/Medicare for information on how to obtain needed care during a disaster.

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

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

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

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

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

Presbyterian Senior Care Plan 1 (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

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

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

Section 5.1 What is a “clinical research study”?
--

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

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

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

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

clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

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

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

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

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

Do you want to know more?

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

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

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

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

Section 6.2 Receiving care from a religious non-medical health care institution

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

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

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

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

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

- 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.

For more information about our plan's limitations, cost-sharing and benefits, please refer to Chapter 4 Medical Benefits Chart, Inpatient Hospital for coverage limitations.

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 Presbyterian Senior Care Plan 1 (HMO), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call customer service for more information.

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

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

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You

then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Presbyterian Senior Care Plan 1 (HMO) will cover:

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

If you leave Presbyterian Senior Care Plan 1 (HMO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart

*(what is covered and
what you pay*

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Presbyterian Senior Care Plan 1 (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is \$4,000.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$4,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you
--

As a member of Presbyterian Senior Care Plan 1 (HMO), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan.

Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

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

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

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

The Medical Benefits Chart on the following pages lists the services Presbyterian Senior Care Plan 1 (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in bold as, “**Authorization is required**” or “**Authorization rules may apply**” or “**Pre-Service Authorization is required.**”
- If you need transitional/concurrent care when you elect hospice, your hospice provider will develop and submit a care plan to us with the services you need. While this is not a prior authorization, without a care plan we cannot pay for these additional services. See Hospice Care in the Medical Benefits Chart in Chapter 4, Section 2.1.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. **However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.**
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees Participating in Wellness and Health Care Planning (WHP) Services


Because Presbyterian Senior Care Plan 1 (HMO) participates in the Diabetes Disease Management program that covers hospice, you will be eligible for the following WHP services, including advance care planning (ACP) services:

- To receive the additional benefits under hospice, your provider will need to submit your notice of hospice election and a care plan, if appropriate. For further detail, please refer to the “Hospice care” row in the Medical Benefits Chart below. As part of this program, we encourage you to work with your provider or the plan to complete your advanced care planning.






You will see this apple next to the preventive services in the benefits chart. **The applicable cost-sharing will apply to any non-preventive services you receive during this visit.**




Medical Benefits Chart


Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances. For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • 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.	You pay a \$20 copayment per visit

Services that are covered for you	What you must pay when you get these services
<p>Acupuncture for chronic low back pain (continued)</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable states requirements and have:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Covered services include:</p> <p>Routine visits, up to 25 visits per year</p>	<p>You pay a \$20 copayment per visit</p>

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services</p> <ul style="list-style-type: none"> Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. We also cover the services of a licensed ambulance without prior authorization (including transportation through the 911 emergency response system where available) to the nearest appropriate facility if you believe that you have an emergency medical condition and that your condition requires the clinical support of ambulance transport services. One copayment per day per trip when there is more than one trip in a single day. Copayment is not waived if admitted. 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. 	<p>Authorization required for non-emergency Medicare-covered service.</p> <p>You pay a \$250 copayment per one-way trip.</p> <p>No charge if you are transferred from one facility to another during a hospitalization.</p> <p>You may be responsible for 100% of the costs incurred when services are not medically necessary.</p>
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Services that are covered for you	What you must pay when you get these services
 Bone mass measurement <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
 Breast cancer screening (mammograms) <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> <ul style="list-style-type: none"> • Maximum of 36 sessions per calendar year with the option for an additional 36 sessions based on medical necessity. 	<p>No Charge</p>

Services that are covered for you	What you must pay when you get these services
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation • Routine visits, up to 25 visits per year 	You pay a \$20 copayment per visit

Services that are covered for you	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>

Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:

You pay a \$50 copayment



- Medically-necessary services by a dentist or an oral surgeon for surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, or services that would be covered when provided by a medical provider.


Basic Dental

- Periodic oral evaluation, extensive oral exams, re-evaluation-limited problem focused – two every 12 months.
- Limited oral exams – three per 12 months.
- Comprehensive oral exam and comprehensive periodontal evaluation - one every 36 months per provider or location.
- Palliative treatment.
- Prophylaxis, scaling in presence of generalized moderate or severe gingival inflammation, full mouth – two every 12 months.
- Periodontal maintenance procedures (following active therapy) four every 12 months.
- Topical application of fluoride varnish, topical fluoride – two every 12 months.
- Bitewings (one, two, three, four images) or intraoral tomosynthesis-bitewing radiographic image – one every 12 months.
- Intraoral complete series, vertical bitewings, panoramic radiographic image or intraoral tomosynthesis-comprehensive series of radiographic image-once every 36 months.
- Intraoral periapical image or intraoral tomosynthesis-periapical image – one every 12 months.
- Intraoral occlusal radiographic image – two every 24 months.

You pay a \$0 copayment for all services.


For more information about Comprehensive Dental Plan benefits, see Section 2.2 (Extra “optional supplemental” benefits you can buy).

Services that are covered for you	What you must pay when you get these services
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	What you must pay when you get these services
 Diabetes self-management training, diabetic services and supplies <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Blood glucose monitors, test strips, and lancets ○ Standard test strips and lancets are limited to a quantity limit of 100 per 30 days for non-insulin dependent members and 200 per 30 days for insulin dependent members • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 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. • Diabetes self-management training is covered under certain conditions 	<p>No Charge</p> <p>Coverage is limited to Accu-Chek branded products</p> <p>You pay a 20% coinsurance</p> <p>No Charge</p>
<p>*Continuous Glucose Monitors (CGM) and Supplies are covered under Durable Medical Equipment (DME) services. Authorization rules apply. Please refer to the DME section for coinsurance information on CGM products.</p>	<p>Authorization rules apply for continuous glucose monitor products.</p>

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this document as well as Chapter 3, Section 7.)</p> <p>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.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our DME supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. For the most recent list of DME suppliers available in our provider directory, please contact customer service.</p> <p>Generally, Presbyterian Senior Care Plan 1 (HMO) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to Presbyterian Senior Care Plan 1 (HMO) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)</p> <p>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, <i>What to do if you have a problem or complaint (coverage decisions, appeals, complaints).</i>)</p>	<p>Authorization rules may apply.</p> <p>No charge on ostomy supplies</p> <p>You pay a 20% coinsurance</p> <p>Your cost sharing for Medicare oxygen equipment coverage is a <i>20% coinsurance every month</i></p> <p>Your cost sharing will not change after being enrolled for 36 months.</p> <p>If prior to enrolling in Presbyterian Senior Care Plan 1 (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Presbyterian Senior Care Plan 1 (HMO) is 20% coinsurance every month</p>


Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>You have worldwide emergency coverage.</p> <ul style="list-style-type: none"> • If you are admitted to the hospital within 24 hours, you do not have to pay your emergency room copayment. • Emergent air and ground transportation is covered to the nearest appropriate facility. • You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 7, Section 2). 	<p>In- and out-of-network:</p> <p>You pay a \$110 copayment per emergency department visit</p> <p>This copayment does not apply if you are admitted to the hospital within 24 hours for the same condition.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered <i>OR</i> you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital.</p>

Services that are covered for you	What you must pay when you get these services
<p>Genetic testing and consultation</p> <ul style="list-style-type: none"> Genetic counseling by an appropriately licensed individual (in support of anticipated genetic testing or to discuss the results of genetic testing) Genetic testing is covered as determined by regulatory statute and medical necessity criteria based on peer-reviewed clinical guidelines and professional organizations 	<p>Pre-Service authorization is required.</p> <p>PCP office visits: You pay a \$0 copayment</p> <p>Specialist visits: You pay a \$50 copayment</p> <p>No Charge</p>
<p> Health and wellness education programs</p> <p>We cover a variety of health educations counseling programs to help you take an active role in protecting and improving your health, including programs for chronic medical conditions. These are programs focused on health conditions such as:</p> <ul style="list-style-type: none"> Asthma Chronic obstructive pulmonary disease (COPD) Congestive heart failure Coronary artery disease Diabetes Hypertension Nutrition Obesity Stress management Tobacco-cessation <p>For more information about our health education counseling, classes, programs and materials, please contact customer service at (505) 923-6060 or 1-800-797-5343 (TTY 711).</p>	<p>There is no coinsurance, copayment, or deductible for health and wellness education programs.</p>

Services that are covered for you	What you must pay when you get these services
<p>Healthways SilverSneakers® Fitness Center Memberships</p> <p>SilverSneakers® Membership</p> <p>SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations¹. You have access to instructors who lead specially designed group exercise classes at participating locations nationwide¹. You can take classes² plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE, SilverSneakers On Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your personal SilverSneakers® ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY 711) Monday through Friday, 8 a.m. to 8 p.m. ET.</p> <p>Always talk with your doctor before starting an exercise program.</p> <ol style="list-style-type: none"> 1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. <p>SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers Go are trademarks of Tivity Health, Inc.</p> <p>© 2022 Tivity Health, Inc. All rights reserved.</p>	No Charge

Services that are covered for you	What you must pay when you get these services
<p>Hearing services</p> <p>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.</p> <ul style="list-style-type: none">• One (1) routine hearing exam each year• The applicable cost-sharing will apply to any additional exams.	<p>No Charge</p>

Services that are covered for you	What you must pay when you get these services
Hearing Aids	
<p>Up to two TruHearing approved hearing aids every year (one per ear per year). TruHearing's Advanced and Premium hearing aids come in various styles and colors.</p>	<p>You pay a \$699 copayment per TruHearing Advanced hearing aid.</p>
<p>Rechargeable battery option is available on select styles for an additional \$50 per hearing aid.</p>	<p>You pay a \$999 copayment per TruHearing Premium hearing aid.</p>
<p>You must see a TruHearing provider to use this benefit.</p>	<p>TruHearing-branded hearing aids only.</p>
<p>Hearing aid purchase includes:</p>	
<ul style="list-style-type: none"> • 1 year of follow-up provider visits • Risk-free 60-day trial period • Full 3-year manufacturer warranty • 80 free batteries per non-rechargeable hearing aid 	
<p>Benefit does not include or cover any of the following:</p>	
<ul style="list-style-type: none"> • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits after 1 year after purchase • Additional batteries or rechargeable • Hearing aids that are not approved TruHearing hearing aids • Costs associated with loss and damage warranty claims 	
<p>Costs associated with excluded items are the responsibility of the member and not covered by the plan.</p>	
<p>Hearing aid costs do not apply toward the maximum out-of-pocket amount.</p>	

Services that are covered for you	What you must pay when you get these services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none">• One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none">• Up to three screening exams during a pregnancy	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>

Home health agency care

Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

Covered services include, but are not limited to:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

Home health care services are provided by Presbyterian Home Health. If another agency is preferred, the agency must be part of the Presbyterian network and services require prior authorization through Presbyterian Health Plan.

Non-covered services include, but are not limited to:

- Custodial care
- Personal care attendant
- Personal care services (PCS)

Note:

- A home health aide cannot provide the services by himself or herself, a nurse needs to be present.
- Both the nurse and the aide are considered intermittent. This means they are there for the services needed (such as when the home health aide helps with a bath) and do not stay to assist with custodial care. Skilled nursing means you need a nurse for such things as wound care, catheter care, medication changes, etc.

Authorization is required.

No Charge

There is no cost-sharing for medical equipment and supplies covered under the home health benefit in accordance with Medicare guidelines.

However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit, for example, durable medical equipment and related supplies.

You are responsible for 100% of the costs.

Services that are covered for you	What you must pay when you get these services
<p>Home infusion therapy</p> <p>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).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring service for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	<p>Prior Authorization may be required.</p> <p>No Charge</p> <p>Any applicable cost-sharing may also apply to Part B prescription drugs you receive during the appointment.</p>

Hospice care

You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal diagnosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

- Counseling Services performed by licensed social workers and chaplains
- DME equipment related to your terminal diagnosis
- Drugs for symptom control and pain relief
- Home care
- Nursing and Physician Services
- Short-term respite care
- Transitional care plan benefits, typically for the first 30 days of hospice election, when requested by your in-network hospice provider as part of a care plan.

When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal diagnosis: While you are in the hospice program, your hospice provider will bill Presbyterian Senior Care Plan 1 (HMO).

For services that are covered by Medicare Part A or B and are not related to your terminal diagnosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal diagnosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).

When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal diagnosis are paid for by Presbyterian Senior Care Plan 1 (HMO), not Original Medicare.

You pay applicable plan cost-sharing for transitional care benefits requested by your provider.

Hospice care (continued)


- If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services
- If you obtain covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

You pay your plan cost-sharing amount for these services.

For services that are covered by Presbyterian Senior Care Plan 1 (HMO) but are not covered by Medicare Part A or B: Presbyterian Senior Care Plan 1 (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal diagnosis. You pay your plan cost-sharing amount for these services.

Note: If you need non-hospice care (care that is not related to your terminal diagnosis), you should contact us to arrange the services.

Services that are covered for you	What you must pay when you get these services
<p>Hospital Re-admission Prevention Program</p> <p>A program following a discharge from a hospital or skilled nursing facility (SNF) stay, to help prevent re-admission.</p> <p>Unless otherwise specified, the benefits are provided to you 30 days post-discharge and include:</p> <ul style="list-style-type: none"> • In-Home Safety Assessment • Home and bathroom safety devices • Medication Reconciliation • Post Discharge In-Home Medication Reconciliation • Transportation (First 30-days post discharge to follow-up clinical visits) 	<p>No Charge</p>
<p>Hospital Re-admission Prevention Program for Members on Hospice</p> <p>A program following a discharge from an inpatient hospital or skilled nursing facility (SNF), to help prevent re-admission.</p> <p>These benefits are available only if you use in-network hospice providers and must be ordered by your hospice provider as part of your care plan.</p> <p>Unless otherwise specified, the benefits are provided to you 30 days post-discharge and include:</p> <ul style="list-style-type: none"> • In-Home Safety Assessment • Home and bathroom safety devices • Meals – 60 meals over the course of the Hospice Election • Transportation (First 30-days post discharge to follow-up hospice-related visits) 	<p>No Charge</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B Services related to your terminal diagnosis are paid for by Presbyterian Senior Care Plan 1 (HMO), not Original Medicare.</p>

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>
<p>Inpatient hospital care</p> <p>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.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services 	<p>Authorization is required.</p> <p>Per admission, you pay a copayment of \$325 per day for days 1-5.</p> <p>There is no charge for the remainder of your covered hospital stay and no limit to the number of days covered by the plan based on medical necessity.</p>

Inpatient hospital care (continued)

- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Presbyterian Senior Care Plan 1 (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.
- Physician services

Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at


<https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.


Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued)	
<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>	
<p>If you are admitted to the hospital in 2023 and are not discharged until sometime in 2024, the 2023 cost-sharing will apply to that admission until you are discharged from the hospital or skilled nursing facility.</p>	
<p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered, but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>	

Services that are covered for you	What you must pay when you get these services
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>To arrange for covered services, please call customer service.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p> <p>If you are admitted to the hospital in 2023 and are not discharged until sometime in 2024, the 2023 cost-sharing will apply to that admission until you are discharged from the hospital or skilled nursing facility.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered, but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>	<p>Authorization is required.</p> <p>Per admission, you pay a copayment of \$325 per day for days 1-5.</p> <p>There is no charge for the remainder of your covered hospital stay and no limit to the number of days covered by the plan based on medical necessity.</p>

Services that are covered for you	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>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:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • 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 • Physical therapy, speech therapy, and occupational therapy 	<p>You are responsible for 100% of the costs.</p>

Services that are covered for you	What you must pay when you get these services
<p data-bbox="196 369 971 422">Meals Benefit</p> <p data-bbox="196 432 971 548">This program is uniquely designed to keep you healthy and strong while you are recovering after transitioning from an inpatient hospital or skilled nursing facility (SNF) stay:</p> <ul data-bbox="196 558 971 825" style="list-style-type: none"><li data-bbox="196 558 971 705">• The meal benefit is offered to members only after each inpatient hospital or skilled nursing facility discharge and must be ordered by a physician or non-physician practitioner as part of the discharge planning process.<li data-bbox="196 705 971 825">• 30 meals maximum during the 30 days following discharge.	<p data-bbox="987 369 1404 422">No Charge</p>

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p> <p>Additional Medical Nutrition Therapy (MNT) Sessions:</p> <p>There are no limits on the number of medical nutrition therapy (MNT) sessions provided by a registered dietician or other nutrition professional.</p> <p>Non-covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Weight-loss treatment, including but are not limited to: <ul style="list-style-type: none"> ○ Dietary supplements ○ Exercise and weight loss programs ○ Medications ○ Self-help groups 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>You are responsible for 100% of the costs.</p>

Services that are covered for you	What you must pay when you get these services
 Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. For more information about the Medicare Diabetes Prevention Program, please contact The Solutions Group at (505) 923-5454 to leave a message, (TTY 711) or email them at wellness@phs.org .	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Medicare Part B prescription drugs

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

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)
- We also cover some vaccines under our Part B prescription drug benefit
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
- Drugs and/or drug categories that may be subject to Step Therapy include: Prolia, Xgeva (denosumab), Viscosupplementation, Botox (onabotulinumtoxinA), Avastatin (bevacizumab), Rituxan (rituximab), Intravenous Immune Globulin (IVIG), Filgrastim/Pegfilgrastim, Remicade (infliximab) This list is subject to change. Please visit the link below for the most up to date version.

Medicare Part B drugs may require prior authorization.

Drugs may also be subject to Step Therapy requirements.

You pay a \$10 copayment for up to a 30-day supply for Part B prescription drugs when purchased through a retail pharmacy.

You pay a 20% coinsurance for Part B drugs that are administered by a provider.


Effective April 1, 2023:

Certain Part B rebatable drugs may be subject to a lower coinsurance.

If administered through a provider's office, some medications are required to be obtained through the designated specialty network provider and delivered to the facility that your provider's office.

Effective July 1, 2023:

For insulin given through DME (i.e. insulin pumps), cost sharing is subject to a coinsurance cap of \$35 for a one-month supply of insulin.

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs (continued)</p> <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy:</p> <p>https://onbaseext.phs.org/PEL/DisplayDocument?ContentID=PEL_00956495</p>	
<p>Nursing Hotline – PresRN</p> <p>You have member access to PresRN, a nurse advice line service that is available 24-hours a day, seven days a week, including holidays.</p> <p>For more information, see Chapter 3, section 3.2.</p> <p>(505) 923-5573</p> <p>(Subject to applicable local/long distance charges, depending on your phone plan.)</p>	<p>No Charge</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

Services that are covered for you	What you must pay when you get these services
<p data-bbox="196 380 971 422">Opioid treatment program services</p> <p data-bbox="196 432 971 579">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:</p> <ul data-bbox="196 600 971 976" style="list-style-type: none"><li data-bbox="196 600 971 705">• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.<li data-bbox="196 705 971 789">• Dispensing and administration of MAT medications (if applicable)<li data-bbox="196 789 971 821">• Substance use counseling<li data-bbox="196 821 971 863">• Individual and group therapy<li data-bbox="196 863 971 905">• Toxicology testing<li data-bbox="196 905 971 936">• Intake activities<li data-bbox="196 936 971 976">• Periodic assessments	<p data-bbox="987 432 1414 506">You pay a \$0 copayment per visit</p>

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies	Authorization rules may apply.
Covered services include, but are not limited to:	No Charge
<ul style="list-style-type: none"> • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Allergy evaluation and testing • Allergy injections • Allergy testing and treatment materials administered during a covered visit • Diagnostic mammograms • Diversion of nuclear stress-to-stress echo studies • Electrocardiograms • Electroencephalogram • Nuclear cardiology • Sleep studies 	You pay a \$20 copayment
• X-rays and ultrasounds	You pay a \$20 copayment
• Therapeutic Radiological Services	You pay a 20% coinsurance
<ul style="list-style-type: none"> • Other outpatient diagnostic tests <ul style="list-style-type: none"> ○ Computed tomography (CT) ○ Magnetic resonance angiogram (MRA) ○ Magnetic resonance imaging (MRI) ○ Positron emission tomography (PET) 	Authorization is required.
<ul style="list-style-type: none"> • Bone mass measurement <ul style="list-style-type: none"> ○ For information on bone densitometry, refer to “bones mass measurement” services in this chart. 	You pay a \$300 copayment

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>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.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>You pay a \$110 copayment</p>

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 or outpatient clinic, such as observation services or outpatient surgery

- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it

- X-rays, ultrasounds and other radiology services billed by the hospital

- Laboratory and diagnostic tests billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can't give yourself

Authorization rules may apply.

In- and out-of-network:

Emergency department visits:

You pay a \$110 copayment per visit

Outpatient surgery:

You pay a \$325 copayment when it is provided in an outpatient or ambulatory surgical center

No charge for individual or group therapy visits

You pay a \$50 copayment for partial hospitalization for psychiatric treatment

You pay a \$20 copayment

No Charge

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
<p>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.</p>	
<p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
Outpatient mental health care	
<p>Covered services include:</p> <p>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.</p> <p>You may receive an unlimited number of individual and group therapy counseling sessions.</p> <p>To arrange for covered services, please call the Behavioral Health line at 1-800-424-4657.</p>	<p>No charge for individual or group therapy visits</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay a \$20 copayment for each visit</p>
<p>Outpatient substance abuse services</p> <p>Substance abuse 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.</p> <p>We provide treatment and counseling services to diagnose and treat substance abuse including:</p> <ul style="list-style-type: none"> • Group therapy visits • Individual therapy visits <p>To arrange for covered services, please call the Behavioral Health line at 1-800-424-4657.</p>	<p>No Charge</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>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.”</p>	<p>Authorization rules may apply.</p> <p>You pay a \$325 copayment</p>



Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services</p> <p>“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.</p> <p>To arrange for covered services, please call the Behavioral Health line at 1-800-424-4657.</p>	<p>Authorization rules may apply.</p> <p>You pay a \$50 copayment for partial hospitalization for psychiatric treatment</p>



Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits	
Covered services include:	
<ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Second opinion by another network provider prior to surgery • 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) • Certain telehealth services include: <ul style="list-style-type: none"> ○ PCP/other health care professional services, specialist services ○ Outpatient rehabilitation services including physical, occupational, and speech language therapy ○ Urgently needed services ○ Individual and group sessions for mental health specialty, psychiatric, and outpatient substance use disorder services 	<p>Outpatient ambulatory surgery: You pay a \$325 copayment</p> <p>PCP office visit/other health care professionals: You pay a \$0 copayment</p> <p>Specialist visits: You pay a \$50 copayment</p>
You have the option of getting these services through an in-person visit or by telehealth.	No Charge
If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.	
Cost-sharing for other types of telehealth service categories is the same as services rendered in person.	


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

- Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home No Charge
- Telehealth services to diagnose, evaluate or treat symptoms of a stroke regardless of your location
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
 - You have an in-person visit within 6 months prior to your first telehealth visit
 - You have an in-person visit every 1 months while receiving these telehealth services
 - Exceptions can be made to the above for certain circumstances
- Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
 - You're not a new patient **and**
 - The check-in isn't related to an office visit in the past 7 days **and**
 - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
 - You're not a new patient **and**
 - The evaluation isn't related to an office visit in the past 7 days **and**
 - The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your doctor has with other doctors by phone, internet, or electronic health record

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <p>Video Visits</p> <p>Video Visits give you access to health care providers licensed in New Mexico, anytime, without an appointment, from your:</p> <ul style="list-style-type: none"> • Home • Office • Other location with mobile data or Wi-Fi access <p>Schedule an appointment on your:</p> <ul style="list-style-type: none"> • Computer (with a working webcam) • Smartphone • Tablet <p>Professional primary/specialty care:</p> <ul style="list-style-type: none"> • Get diagnosed for non-urgent illnesses such as: <ul style="list-style-type: none"> ○ Allergies ○ Fevers ○ Flu ○ Sore throats • Receive prescriptions (when clinically appropriate) <p>Speak with a provider 24 hours a day, 365 days a year. Video Visits are secure, confidential, and compliant with all medical privacy regulations.</p>	<p>No Charge</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>No Charge</p>

Services that are covered for you	What you must pay when you get these services
 Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.	Authorization rules may apply. No Charge on prosthetic medical supplies such as ostomy supplies, surgical dressing, splints, and casts that cannot be reused by the member All other prosthetic medical supplies will apply the 20% coinsurance
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. <ul style="list-style-type: none"> • Maximum of 36 sessions per calendar year with the option for an additional 36 sessions based on medical necessity. 	No Charge
 Routine physical exams Routine physical exams are covered if the exam is medically appropriate, preventive care in accord with generally accepted professional standards of practice. <ul style="list-style-type: none"> • One per calendar year 	There is no coinsurance, copayment, or deductible for a routine physical exam.

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p> <p>To arrange for covered services, please call the Behavioral Health line at 1-800-424-4657.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>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 place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Services to treat kidney disease

Covered services include:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)

You pay a 20% coinsurance

- Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)

Authorization is required.

Per admission, you pay a \$325 copayment per day for days 1-5.


There is no charge for the remainder of your covered hospital stay and no limit to the number of days covered by the plan based on medical necessity.

- 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
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

No Charge


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.”


Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this document. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only 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 <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital 	<p>Authorization is required.</p> <p>Per admission, you pay: No charge for days 1-20</p> <p>\$95 copayment per day for days 21-100</p> <p>You are covered for up to 100 days in SNF. You are responsible for 100% of the costs for days 101 and beyond per admission.</p>

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>Quit for Life® is the nation's leading tobacco cessation program that helps participants overcome physical, psychological and behavioral addictions to tobacco through coaching, nicotine replacement therapy (as appropriate), a customized quitting program, and a supportive online community. Telephone and web-based tobacco cessation services available.</p> <p>For more information about the Quit for Life® Program, call 1-866-QUIT.4.LIFE or visit www.quitnow.net.</p> <p>Clickotine is a mobile application that helps you create and stick to a quit plan and overcome nicotine cravings.</p> <p>Call customer service at the number on the back of your member ID card for details on accessing the Clickotine App. You can also visit www.clickotine.com for more information.</p> <p>Additional smoking cessation counseling sessions:</p> <p>There are no limits on the number of counseling sessions in person or telephone coaching visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>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.</p>	<p>No Charge</p>

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network.</p> <p>Inside our service area: You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstances (for example, major disaster).</p> <p>Outside our service area: You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believe that your health would seriously deteriorate if you delayed treatment until you returned to our service area. See Chapter 3, Section 3.2, for more information</p>	<p>In-network: You pay a \$15 copayment per visit</p> <p>Out-of-network: You pay a \$60 copayment per visit</p>

Services that are covered for you	What you must pay when you get these services
 Vision care	
Covered services include:	
<ul style="list-style-type: none"> • One annual routine exam • 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 • For people with diabetes, screening for diabetic retinopathy is covered once per year 	No Charge
<ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts 	You pay a \$10 copayment
<ul style="list-style-type: none"> • Routine prescription eyewear allowance for frames, lenses, contacts, and contact lens fittings 	\$250 allowance every year
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) 	You pay a 20% coinsurance

Services that are covered for you	What you must pay when you get these services
 “Welcome to Medicare” Preventive Visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

Section 2.2 Extra “optional supplemental” benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package. These extra benefits are called **“Optional Supplemental Benefits.”** If you want these optional supplemental benefits, you must sign up for them: and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

Optional Supplemental Benefit Chart

Services that are covered for you	What you must pay when you get these services
Comprehensive Dental Plan Our optional Comprehensive Dental Plan is in addition to the Basic Dental Plan which you will be automatically enrolled in. (For more information on what your Basic Dental Plan covers, please go to the “Dental Services” row above in the Medical Benefits Chart.) The Comprehensive Dental Plan offers dental benefits that are not covered by Original Medicare.	

Comprehensive Dental Plan (continued)

- There is no deductible or waiting period.
- The maximum calendar year benefit is \$4,000 for covered services performed in-network only. You are responsible for any service provided by a non-network provider.
 - This amount does not count toward your plan out-of-pocket maximum detailed in Chapter 4, Section 1.2.
 - You are responsible for any services over the annual maximum.
 - Unused portion of the annual maximum does not carry forward to next year's benefit.
- Covered services (20% coinsurance):

You pay a 20% coinsurance

 - Amalgam and Resin fillings, resin infiltration of incipient smooth surface lesion - 1 per tooth surface/24 mos.
 - In/Onlays - 1 per tooth/60 mos.
 - Protective Restorations - 1 per tooth/lifetime.
 - Recement or re-bond inlay, onlay, partial restoration, crown - 1 per tooth/24 mos.
 - Extractions and coronectomy - 1 per tooth/lifetime.
 - Adjust dentures - two adjustments per arch/12 mos.
 - Repair dentures - 1 per arch/12 mos.
 - Repair base or framework or replace missing or broken tooth or clasp, add tooth & clasp on dentures - 1 per tooth/12 mos.
 - Rebase and reline dentures - 1 per 36 mos.
 - Tissue conditioning - 1 per 60 mos after new denture.
 - Re-cement, repairs of partial dentures - 1 per 24 mos.
- Covered services (50% coinsurance):

You pay a 50% coinsurance

 - Crowns, core build-up, pin retention-per tooth, post and core, each additional post - 1 per tooth/60 mos.
 - Crown repair necessitated by restorative material failure - 1 per 24 mos.
 - Pulpotomy and gross pulpal debridement of tooth - 1 per tooth/lifetime.

Services that are covered for you	What you must pay when you get these services
Comprehensive Dental Plan (continued)	
If you want these optional supplemental dental benefits, you must sign up for them and pay an additional premium of \$9 per month.	
You can enroll in the Comprehensive Dental Plan anytime, and your coverage will become effective the first day of the following month. For information on how to enroll, you can contact customer service.	
If you disenroll from your Comprehensive Dental Plan during the year, you must wait until the next annual enrollment period to re-enroll. For information on how to disenroll from your plan, you can contact customer service.	

SECTION 3 What services are not covered by the plan?

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under circumstances.
Cosmetic surgery or procedures		<ul style="list-style-type: none"> Covered in cases of an accidental injury or for improving 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
<p>Custodial care</p> <p>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.</p>	✓	
<p>Experimental medical and surgical procedures, equipment and medications</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home	✓	
Home-delivered meals		After an inpatient hospital or skilled nursing facility (SNF) discharge. Under certain circumstances during your hospice election period. Please refer to Hospital Readmission Prevention Program for Members on Hospice in the Medical Benefits Chart.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	✓	
Hospice transitional care plan benefits, typically for the first 30 days of hospice election		When requested by your in-network hospice provider as part of your care plan.
Hospice Readmission Prevention Program		When requested by your in-network hospice provider as part of your care plan.
Naturopath services (uses natural or alternative treatments)	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Optional Supplemental Comprehensive dental benefits	✓ Bone grafts, cosmetic procedures, implants and all associated services, services not listed in Chapter 4, section 2.2.	
Optional Supplemental Comprehensive dental benefits		Refer to the Comprehensive Dental benefits in Chapter 4, section 2.2.
Over-the-counter Hearing Aids	✓	
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	✓	
Private room in a hospital		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	✓	
Radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g. if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids.		TruHearing approved hearing aids and providers only
Services considered not reasonable and necessary according to Original Medicare standards	✓	
Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of the license	✓	
Care in a licensed intermediate care facility, unless covered by Medicare (such as covered home health care or hospice care)	✓	
Care in a residential facility where you stay overnight, except for care covered by Medicare or a licensed facility providing covered transitional residential recovery services described in the Medical Benefits Chart	✓	
Chelation therapy	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Consultations for non-covered benefits	✓	
Disposable supplies for home use, such as bandages, gauze tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies		Unless covered by Medicare (for example, ostomy or diabetic supplies).
Drugs that do not meet the definition of Part B	✓	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance		Except when medically necessary.
Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits	✓	
Routine prescription eyewear items.		Amounts covered up to the established \$250 benefit allowance.
Massage therapy		Except when ordered as part of a physical therapy program in accord with Medicare guidelines.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
New medical procedures, behavioral health care procedures, pharmaceutical drugs, and devices (or existing ones used differently)		New technology, devices or procedures are covered only if mandated by CMS or approved by the Technology Assessment Committee. The Technology Assessment Committee is comprised of in-network practitioners with input from local practitioners and clinical staff.
Outpatient oral nutrition, such as dietary supplements and herbal supplements	✓	
Outpatient prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy	✓	
Over-the-counter drugs such as bandages, cough/cold medicines, pain relievers and vitamins	✓	
Replacement of drugs due to being lost, stolen, damaged or destroyed		Except during a declared state of disaster or emergency.
Routine care not associated with the clinical trial is subject to all terms, conditions, and restrictions, exclusions, and other coverage under our plan	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine or elective services, including lab work or medical care, when provided by non-plan providers without prior approval by Presbyterian Health Plan's Medical Director	✓	
Routine transportation or transportation by car, taxi, bus, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider		Unless authorized as part of the Re-admission Prevention Program or the Readmission Prevention Program for Hospice Members described in the Medical Benefits Chart
Services for any illnesses or injury that occurs in the course of employment and which you are eligible for compensation under any worker's compensation act or employer liability law, regardless of whether you claim the benefits or recover losses from a third party	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that, by law, require federal FDA approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside of the U.S. It does not apply to Medicare-covered clinical trials or covered emergency care you receive outside of the U.S. Services provided to veterans in Veterans Affairs (VA) facilities.		When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Surgical treatment for morbid obesity		Except when it is considered medically necessary and covered under Original Medicare
Take-home outpatient prescription drugs	✓	
When a service or item is not covered, all services related to the non-covered service or item are excluded		Except for services or items we would otherwise cover to treat complications of the non-covered service or item, or if covered in accord with Medicare guidelines

CHAPTER 5:

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

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

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

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

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

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

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, you are only responsible for paying your share of the cost. 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, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

Chapter 5 Asking us to pay our share of a bill you have received for covered medical services

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

3. If you are retroactively enrolled in our plan

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

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

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

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

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

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

- You don’t have to use the form, but it will help us process the information faster. We need to know the following information about you:
 - First name, middle initial, and last name
 - Date of birth
 - Member ID number

Chapter 5 Asking us to pay our share of a bill you have received for covered medical services

- Group number (if applicable)
 - Mailing address, phone number, and email address
 - Nature of the condition/treatment you received including the date of service and dates of prior consultations or treatments related to this claim
 - Information about any additional health insurance coverage you have
 - Provider's name, address, and phone number
 - Attach a copy of the itemized statement or charge form
- Either download a copy of the form from our website (www.phs.org/Medicare) or call customer service and ask for the form.

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

Presbyterian Senior Care (HMO)

P.O. Box 27489

Albuquerque, NM 87125-7489

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

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

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

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

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

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

CHAPTER 6:

Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. This information is available in Spanish at no cost. 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.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with customer service. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1	Tenemos que proporcionar información de una manera que pueda entender y que es consistente con sus sensibilidades culturales (en idiomas además del inglés, en braille, en letra grande o en otros formatos, etc.)
--------------------	---

Se exige que nuestro plan asegure que todos los servicios, tanto clínicos como no clínicos, se presten de manera culturalmente adecuada y estén accesibles para todos los inscritos cuyo dominio del inglés es limitado, cuya capacidad de leer es limitada, cuyos antecedentes étnicos y culturales son diversos o que tengan discapacidades auditivas. Unos ejemplos de cómo un plan puede cumplir esos requisitos de accesibilidad incluyen, entre otros, ofrecer servicios de

Chapter 6 Your rights and responsibilities

traducción, servicios de intérpretes, servicios de teletipo o conexión al sistema TTY (teléfono de texto o teléfono de teletipo).

Nuestro plan tiene disponibles servicios gratuitos de intérpretes para contestar las preguntas de los asegurados que no hablen inglés. Además, le podemos aportar información en braille, en letra grande o en otros formatos sin costo alguno, si lo necesita. Se exige que le aportemos la información sobre los beneficios del plan en un formato accesible y adecuado para usted. Para que le aportemos información de una manera que le convenga a usted, favor de llamar al centro de servicio al cliente.

Se exige que nuestro plan les conceda a las hembras inscritas la opción de acceso directo a un especialista de salud femenina de la red para los servicios de atención médica femenina preventiva y rutinaria.

Si los proveedores de servicios médicos especializados de la red del plan no están disponibles, es la responsabilidad del plan buscar proveedores de servicios médicos especializados fuera de la red para prestarle los servicios de atención médica necesaria. En ese caso, solo pagará los costos compartidos de la red. Si se encuentra en una situación donde no hay especialistas de la red del plan que cubran el servicio que necesita, llame al plan para conseguir información acerca de donde deber ir para conseguir el servicio con los costos compartidos de la red.

Si le es difícil conseguir la información de nuestro plan en un formato accesible y adecuado para usted, favor de llamar al centro de servicio al cliente para presentar una reclamación. Además, puede presentar una queja al Programa Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o llame directamente a la Oficina de Derechos Civiles al 1-800-368-1019 o 1-800-537-7697 para el sistema TTY.

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

Chapter 6 Your rights and responsibilities

Whenever possible, Presbyterian uses or shares health information that doesn't identify you. We have policies and procedures to protect the privacy of health information that does identify you. We have a training program to educate our employees and others about internal protection of oral, written and electronic health information and our privacy policies. Your health information is only used or shared for our business purposes or as otherwise required or allowed by law.

When a service involving your health information is being performed by a third party, we require a written agreement with them to protect the privacy of your health information.

We gave you a copy of our Notice of Privacy Practices when you enrolled, and we share it with you every year in a newsletter. If you want to read it again, you can find the most current copy online at www.phs.org/Medicare. If you want a paper copy, you can contact customer service to request one.

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

As a member of Presbyterian Senior Care Plan 1 (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call customer service:

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

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

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

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

Chapter 6 Your rights and responsibilities

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

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

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

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

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

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

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

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

Chapter 6 Your rights and responsibilities

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the New Mexico Department of Health at the number or address listed below:

New Mexico Department of Health
1190 S. St. Francis Dr.
Santa Fe, NM 87505
(505) 827-2613
nmhealth.org

New Mexico Department of Health Incident Management
Bureau, Abuse, Neglect and Exploitation Reporting
1-800-752-8649
nmhealth.org/contact/report

New Mexico Department of Health Incident Management
Bureau Facilities and Hospitals
1-800-752-8649
nmhealth.org/contact/report

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

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

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

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

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

Is it about something else?

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

- You can **call customer service**.
- You can **call the State Health Insurance Assistance Program**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

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

- You can **call customer service**.
- You may also request a copy of our Rights and Responsibilities Statement and make recommendations to us about our member rights and responsibilities policies.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

Chapter 6 Your rights and responsibilities

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these beliefs.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must continue to pay your premium for your Medicare Part B to remain a member of the plan.
 - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?
--

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, 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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, including 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 prior to receiving services

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 provide medical care you think 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 an appeal request, 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 or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later,

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

you can request an expedited or “fast appeal” of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

If we do not dismiss your case but 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. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals process).

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

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

- **You can call us at customer service.**
- **You can get free help from** your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call customer service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.phs.org/Medicare.
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call customer service ask for the “Appointment of Representative” form. (The form is

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for <u>your</u> situation?

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 7** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to only these services:* home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

keep things simple, we generally refer to “medical care coverage” or “medical care” which 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. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

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

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

Legal Terms
<p>When a coverage decision involves your medical care, it is called an “organization determination.”</p> <p>A “fast coverage decision” is called an “expedited determination.”</p>

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

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services,

24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

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

For Fast Coverage decisions we use an expedited timeframe

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

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

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

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

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

Legal Terms

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

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

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

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

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

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review

organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a “standard appeal”

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint.” When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See section 9 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within seven (7) calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Legal Terms

The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

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

Step 1: The independent review organization reviews your appeal.

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

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

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

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

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

requests. For **expedited requests**, we have **24 hours** from the date we receive the decision from the review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal”). In this case, the independent review organization will send you a letter:
 - Explaining its decision.
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process
 - Telling you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven’t paid for the services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is not covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

**SECTION 6 How to ask us to cover a longer inpatient hospital stay
if you think 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.

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

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

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

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
- 2. You will be asked to sign the written notice to show that you received it and understand your rights.**
- You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
- 3. Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call customer service 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 <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices>.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call customer service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
 - If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling customer service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

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

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

Section 6.4 What if you miss the deadline for making your Level 1 appeal?

Legal Term

A “fast review” (or “fast appeal”) is also called an “**expedited appeal**.”

You can appeal to us instead

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

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

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

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

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

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

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

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

Legal Term

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

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

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

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

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

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

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

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

Section 7.1	<i>This section is only about four services:</i> Home health care, skilled nursing facility care, hospice care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
--------------------	--

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, 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.

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

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

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

Legal Term

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call customer service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

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

Your deadline for contacting this organization.

- 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.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you, or your representative, why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will also get the **Detailed Explanation of Non-Coverage**, from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

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, you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

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

Legal Term

A “fast review” (or “fast appeal”) is also called an “**expedited appeal**.”

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

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

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

- **If we say yes to your appeal**, it means we have agreed with you that you need services longer and will keep providing your covered services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal**, 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, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

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

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

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

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

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

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

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

- **If the Administrative Law Judge or attorney adjudicator says *yes* to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- If we decide *not* to appeal, 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. The notice you get will tell you what to do for a Level 4 appeal.

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the 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 may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none">• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none">• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none">• Has someone been rude or disrespectful to you?• Are you unhappy with our customer service?• Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none">• Are you having trouble getting an appointment, or waiting too long to get it?• Have you been kept waiting too long by doctors, or other health professionals? Or by our customer service or other staff at the plan?<ul style="list-style-type: none">○ Examples include waiting too long on the phone, in the waiting room or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none">• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none">• Did we fail to give you a required notice?• Is our written information hard to understand?

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: <ul style="list-style-type: none"> • You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms
<ul style="list-style-type: none"> • A “Complaint” is also called a “grievance.” • “Making a complaint” is also called “filing a grievance.” • “Using the process for complaints” is also called “using the process for filing a grievance.” • A “fast complaint” is also called an “expedited grievance.”

Section 9.3 Step-by-step: Making a complaint
Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling customer service is the first step.** If there is anything else you need to do, customer service will let you know.
- **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.
- If you have someone submitting a complaint for you, your complaint must include an Appointment of Representative form authorizing this person to represent you. To get the form, call customer service and ask for the “Appointment of Representative” form. It is

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.phs.org/Medicare. While we can accept a complaint 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 complaint request (our deadline for conducting a review), your complaint 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 complaint.

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

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

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

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

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

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

Or

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

**Chapter 7 What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Presbyterian Senior Care Plan 1 (HMO) directly to Medicare.

To submit a complaint to Medicare, go to

www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Presbyterian Senior Care Plan 1 (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

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

- The **Annual Enrollment Period** is from **October 15 to December 7**.
 - **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.
- OR*
- Original Medicare *without* a separate Medicare prescription drug plan.
 - **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

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

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

Chapter 8 Ending your membership in the plan

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period**, you can:
 - Switch to another Medicare Advantage Plan. With or without prescription drug coverage.
 - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan to add drug coverage at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of Presbyterian Senior Care Plan 1 (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
 - Usually, when you have moved.
 - If you have Centennial Care (Medicaid).
 - If we violate our contract with you.
 - If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Chapter 8 Ending your membership in the plan

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

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

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

- **Call customer service.**

You may also request a copy of our Rights and Responsibilities Statement and make recommendations to us about our member rights and responsibilities policies.

- Find the information in the *Medicare & You 2023* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You will automatically be disenrolled from Presbyterian Senior Care Plan 1 (HMO) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Presbyterian Senior Care Plan 1 (HMO) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Send us a written request to disenroll. Contact customer service if you need more information on how to do this.• You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY user should call 1-877-486-2048.• You will be disenrolled from Presbyterian Senior Care Plan 1 (HMO) when your coverage in Original Medicare begins.

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

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

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

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

SECTION 5 Presbyterian Senior Care Plan 1 (HMO) must end your membership in the plan in certain situations

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

Presbyterian Senior Care Plan 1 (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.

Chapter 8 Ending your membership in the plan

- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call customer service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

Presbyterian Senior Care Plan 1 (HMO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, please call us at customer service. 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, Presbyterian Senior Care Plan 1 (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 10:

Definitions of important words

Chapter 10 Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Presbyterian Senior Care Plan 1 (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-A SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

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

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

Chapter 10 Definitions of important words

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress

Chapter 10 Definitions of important words

systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home. Authorization rules apply for continuous glucose monitor (CGM) products.

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

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

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

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

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

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

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

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

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – See “Extra Help.”

Chapter 10 Definitions of important words

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services.

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

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

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

Chapter 10 Definitions of important words

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

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

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

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

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

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

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

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

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) 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. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Presbyterian Customer Service Center – 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 the Presbyterian Customer Service Center.

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

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

Prosthetics and Orthotics – Medical devices 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.

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.

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

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

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

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

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

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 – Covered services that are not emergency services provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Notice of Nondiscrimination and Accessibility

Discrimination is Against the Law

Presbyterian Healthcare Services is committed to equitable healthcare and exists to improve the health of patients, members and the communities we serve. We value diversity and inclusion and strive to treat all individuals with respect. We do not discriminate on the basis of race; color; ancestry; national origin (including limited English proficiency); citizenship; religion; sex (including pregnancy, childbirth or related medical conditions); marital status; sexual orientation; gender identity or expression; veteran status; military status; family care or medical leave status; age; physical or mental disability; medical condition; genetic information; ability to pay; or any other protected status. Presbyterian will provide reasonable accommodations and language access services for our patients, members, and workforce.

Presbyterian Healthcare Services:

- Provides free aids and services to people with disabilities to communicate effectively with use, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Presbyterian Customer Service Center at (505) 923-5420, 1-855-592-7737, TTY 711.

If you believe that Presbyterian Healthcare Services has failed to provide these services or discriminated against you in another way, you can file a grievance with Presbyterian by calling 1-866-977-3021, TTY 711, fax (505) 923-5124, or

<https://ds.phs.org/ewcm/frmExample.do?m=complaintentry&complainttype=customer>.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

Address: U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-592-7737 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-592-7737 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Navajo/Diné: Díí ats'íís dóó azee' bínáí díłkidgo, Dinék'ehjí yadałti'iigi ła' bich'í' hadíídzih. Béesh bee hane'é t'áá jíík'e be' hódíílnih 1-855-592-7737 (TTY: 711).

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-592-7737 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-592-7737 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-592-7737 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-592-7737 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-592-7737 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-592-7737 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-592-7737 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-592-7737 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (1-855-592-7737 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-592-7737 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-592-7737 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-592-7737 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-592-7737 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-592-7737 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-592-7737 (TTY: 711) にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

OUR PRIVACY PRACTICES AND YOUR RIGHTS: JOINT NOTICE 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.

The privacy practices of Presbyterian Healthcare Services ("Presbyterian") and certain organizations that participate in an organized health care arrangement ("OHCA") with Presbyterian are described in this *Joint Notice of Privacy Practices* ("Notice"). Health information about you is contained in our records, but the information in those records belongs to you. This Notice will help you understand how we protect the privacy of your health information and how to complain if you believe your privacy rights have been violated. The terms "we" and "our" used in this Notice refer to Presbyterian and the members of our OHCA that share this Notice and agree to abide by its terms.

HOW WE PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Whenever possible, Presbyterian uses or shares health information that doesn't identify you. We have policies and procedures to protect the privacy of health information that does identify you. We have a training program to educate our employees and others about our privacy policies. Your health information is only used or shared for our business purposes or as otherwise required or allowed by law. When a service involving your health information is being performed by a third party, we require a written agreement with them to protect the privacy of your health information.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide patients, except inmates, with this Notice that describes our legal duties and privacy practices regarding protected health information.
- We have a legal duty to notify you, and you have a right to know when your protected health information has been inappropriately accessed, used, or disclosed as a result of a breach.
- We must follow the terms of the most current *Joint Notice of Privacy Practice*, and are required to ask you for a written acknowledgement that you received a copy.

YOUR HEALTH INFORMATION RIGHTS

You have rights with respect to your protected health information. For more information on how to exercise these rights, see the *How to Make a Request* section of this Notice. The health information rights described in this Notice also apply to a person with legal authority to make health care decisions for a child or other person (for example, a parent or legal guardian). There are exceptions. For example, in New Mexico some health care services can be provided to a minor without the consent of a parent, guardian or other person. In these cases, the minor has the rights described in this Notice for health information related to the health care service provided. Some of the rights described here are subject to certain limitations and conditions.

Right to See and Get a Copy of Health Information. You have the right to see and get a copy of your health information. Usually, this information is contained in medical and billing records. You must make a request in writing to see or get a copy of your health information in our designated record set.

Right to Amend Incorrect or Incomplete Health Information. We strive to ensure that health information kept in our records is accurate and complete. However, occasionally a mistake can occur. You have the right to request that we change incorrect or incomplete health information in our records. We may deny your request if appropriate.

Right to Request Confidential Communications. You have the right to request that we deliver health information to you in a certain way or at a certain location. We must agree to a reasonable request or may deny your request if it is against the law or our policies.

Right to Request Restrictions of the Use or Disclosure of Your Health Information. You have the right to request that your health information is not used or shared for certain purposes. We are not required to agree to your request except if required by law, or if you request restriction to disclosure of your protected health information to the health plan and you pay Presbyterian for those services or health care items in full. We must tell you if we cannot agree to your request.

Right to Request an Accounting of Disclosures. You have the right to request an *Accounting of Disclosures*. This report will show when your health information was shared by us outside of our organization without your written authorization.

Right to Receive a Paper Copy of this Notice. You have a right to receive a paper copy of this Notice, even if you also agreed to receive it electronically.

WHEN HEALTH INFORMATION CAN BE USED OR SHARED WITHOUT A WRITTEN AUTHORIZATION

For Treatment. We use and share your health information to provide medical treatment to you by our health care providers.

For Payment. We use and share your health information in order to receive or facilitate payment for the treatment and services provided to you.

For Health Care Operations. We use and share health information in order to operate our business and deliver quality care and services to our patients.

Required by Law. We will use and share your health information when required by federal, state or local law.

Emergency Situations. We will use professional judgment to decide if sharing your health information is in your best interest during a health emergency or if you are incapacitated.

Public Health Activities. We share your health information with public health authorities to ensure the public welfare.

Health Oversight Activities. Your health information may be shared with health oversight agencies that have authority to monitor our activities.

Legal and Administrative Proceedings. Your health information may be shared as part of an administrative or legal proceeding.

Law Enforcement. If a law enforcement official requests, we may share only very limited health information.

Coroners, Medical Examiners and Funeral Directors. The health information of a deceased person may be shared with coroners, medical examiners and funeral directors so they can carry out their duties.

Organ and Tissue Donation. Your health information may be shared with organizations that obtain, store or transplant human organs and tissues.

Public Safety. Your health information may be shared to prevent or lessen a serious and immediate threat to the health or safety of anyone or the general public.

Special Government Functions. Your health information may be shared with federal officials for national security purposes authorized by law.

Correctional Institutions. If you are an inmate, your health information may be shared with correctional institutions or law enforcement officials in order to protect your health, or the health and safety of others.

Worker's Compensation. Your health information may be used or shared as required by worker's compensation laws.

Change of Ownership. If Presbyterian or any member of the OHCA that shares this Notice is sold or merged with another organization, records that contain your health information will become the property of the new owner.

Secretary of Health and Human Services. We are required by law to share health information with the Secretary of the U.S. Department of Health and Human Services (HHS) when HHS requests the health information to determine our compliance with privacy law.

WHEN A WRITTEN AUTHORIZATION IS REQUIRED TO USE OR SHARE HEALTH INFORMATION

We will not use or share your health information without your written authorization unless required by law or as described in this *Joint Notice of Privacy Practices*. You may cancel an authorization in writing at any time, except to the extent we have already taken action according to the authorization.

Marketing. We do not use or share your health information for marketing purposes without a written authorization from you. There are two exceptions that are permitted: when we have a face-to-face conversation with you or when we give you a promotional gift of little or no monetary value. If a marketing activity would involve any direct or indirect remuneration to us from a third party, the written authorization you would be asked to sign will state that fact.

Research. With your written authorization, we may share your health information with researchers conducting research that has been approved by Presbyterian's Institutional Review Board or another research/privacy board.

Sale of Protected Health Information. We do not sell your health information to anyone.

WHEN YOU MAY RESTRICT OR OPT OUT OF THE USE OR SHARING OF YOUR HEALTH INFORMATION

Facility Directory. Unless you object, we will use your name, your location in our facility, your general medical condition and your religious preference as directory information. Directory information may be shared with members of the clergy of your faith.

Notification and Communication with Family or Others Involved in Your Care. Unless you tell us that you object, we may share your health information with a person involved in your healthcare. If we do so, we may only share the information directly related to that person's involvement in your care or payment for your care.

Disaster Relief Activities. Unless you tell us that you object, we may use and share your health information with a public or private organization legally authorized to assist in disaster relief efforts so that your family can be notified about your condition, status and location.

Fundraising. We may contact you to raise funds for Presbyterian. The money raised is used for health care services and educational programs we provide to the community. Fundraising materials will describe your right to opt out of future fundraising. For more information see the *How to Make a Request* section of this Notice.

PREBYTERIAN'S RIGHT TO CHANGE THIS PRIVACY NOTICE

Presbyterian reserves the right to change the privacy practices described in this *Joint Notice of Privacy Practices* at any time. If the terms of this Notice should change, we will publish a new Notice and post it in our facilities and on our web site. It will be given to you upon request and as required by law. The terms described in the new Notice will apply to all health information maintained by Presbyterian and all members of the OHCA that share this Notice. You may obtain an electronic copy of this Notice from our web site at www.phs.org.

OTHER PARTICIPANTS IN OUR ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

The law allows members of an OHCA to share your health information with each other for certain purposes: for treatment, to receive payment for services, or for the health care operations of the OHCA. The following OHCA members have agreed to follow the privacy practices described in this *Joint Notice of Privacy Practices*:

- Presbyterian Healthcare Services – All facilities
- All facilities and clinics operated, leased or managed by Presbyterian
- Hospital-based physicians and groups who agree with Presbyterian to be subject to this Notice.
- Presbyterian Home Healthcare Services – All divisions

Presbyterian is also a member of an OHCA with Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. which have their own Notice.

HOW TO MAKE A REQUEST: To request a copy of, an amendment to, or an *Accounting of Disclosures* of your health information from Presbyterian, you may contact Health Information Management at (505) 841-1740 or outside Albuquerque at 1-866-352-1528. To request that Fundraising materials not be sent to you, contact: Presbyterian Healthcare Foundation at (505) 724-6580. To file a complaint about our privacy practices, contact the Presbyterian Privacy Official at (505) 923-6176 or the Secretary of HHS, Office for Civil Rights, Region VI, 1301 Young Street, Suite 1169, Dallas, TX 75202. You will not be retaliated against for filing a complaint. For further information, contact Presbyterian's Compliance Dept. at (505) 923-8544.

Effective as of amendment date – August 1, 2013

NUESTRAS PRÁCTICAS REFERENTES A LA PRIVACIDAD Y SUS DERECHOS: NOTIFICACIÓN CONJUNTA DE LAS PRÁCTICAS REFERENTES A LA PRIVACIDAD

Esta notificación describe la manera en que se puede utilizar y divulgar su información médica y cómo usted puede conseguir dicha información. Sirvase repasarla con cuidado.

Las prácticas referentes a la privacidad del Presbyterian Healthcare Services ("Presbyterian") y de ciertas organizaciones que participan en un Acuerdo Organizado de Atención Clínica [OHCA, las iniciales en inglés] con el Presbyterian se describen en esta *Notificación Conjunta de las Prácticas Referentes a la Privacidad* ("notificación"). La información sobre su salud se guarda en nuestros expedientes, sin embargo la información que se contiene en dichos expedientes pertenece a usted. Esta notificación le ayudará a entender cómo protegemos la privacidad de la información sobre su salud y cómo puede presentar una reclamación si usted cree que se han infringido sus derechos a la privacidad. Los términos "nosotros" y "nuestro/a/os/as" que se utilizan en esta notificación se refieren al Presbyterian y a los integrantes de nuestro Acuerdo Organizado de Atención Clínica [OHCA, las iniciales en inglés] que participan en esta notificación y que aceptan cumplir los términos de la misma.

CÓMO PROTEGEMOS LA PRIVACIDAD DE LA INFORMACIÓN SOBRE SU SALUD

Dentro de lo posible, el Presbyterian divulga la información sobre la salud que no le identifica a usted directamente. Tenemos normas y procedimientos para proteger la privacidad de la información sobre la salud que le identifique directamente. Tenemos un programa de capacitación para nuestros empleados y para otras personas con respecto a nuestras prácticas de privacidad. Sólo se utiliza o divulga la información sobre su salud para nuestros fines comerciales o según lo requiera la ley. Si un tercero lleva a cabo un servicio que involucra la información sobre su salud, requerimos que dicho tercero acepte un acuerdo con el fin de proteger la confidencialidad de la información sobre su salud.

NUESTRAS RESPONSABILIDADES

- Por ley, se requiere que protejamos la privacidad de la información sobre su salud.
- Se requiere que proporcionemos a los pacientes, con excepción de los que estén encarcelados, esta notificación que describe nuestras obligaciones legales y nuestras prácticas referentes a la privacidad en lo que se refiere a la información sobre su salud.
- Es nuestra obligación legal avisarle, y usted tiene derecho a saber, si una persona o una entidad ha obtenido acceso inapropiado a la información protegida sobre su salud o si se ha utilizado o divulgado dicha información a causa de una infracción de los medios de protección.
- Debemos cumplir con los términos de nuestra *Notificación Conjunta de las Prácticas Referentes a la Privacidad* más reciente y se requiere que le pidamos que nos firme un acuse de recibo de la copia de dicha notificación.

SUS DERECHOS CON RESPECTO A LA INFORMACIÓN SOBRE SU SALUD

Usted tiene derechos con respecto a la información protegida sobre su salud. Si usted desea recibir más información sobre cómo ejercer esos derechos, consulte la sección de esta notificación sobre *Cómo presentar una petición*. Los derechos referentes a la información sobre la salud que se describen en esta notificación también corresponden a la persona que cuenta con la autoridad legal de tomar decisiones sobre la atención médica de un menor o de otra persona (por ejemplo, los padres o el tutor). Hay excepciones. Por ejemplo, en Nuevo México se pueden prestar algunos servicios de atención médica a los menores sin el consentimiento de los padres, del tutor o de otra persona. En esos casos el menor tiene los derechos que se describen en esta notificación con respecto a la información sobre la salud correspondiente al servicio de atención médica que se haya prestado. Algunos de los derechos que se describen más abajo están sujetos a ciertas restricciones y condiciones.

El derecho a consultar o recibir una copia de la información sobre su salud. Usted tiene derecho a consultar y recibir una copia de la información sobre su salud. Por lo general, esa información se guarda en nuestros expedientes médicos y de cobros. Usted deberá presentar una petición por escrito para consultar o recibir copia de la información sobre su salud que conste en el conjunto de expedientes que se hayan designado.

El derecho a enmendar información sobre su salud que esté incorrecta o incompleta. Nos empeñamos en asegurar que la información sobre la salud que guardamos en nuestros expedientes sea correcta y completa. Sin embargo, ocasionalmente se puede cometer un error. Usted tiene derecho a pedir que modifiquemos la información sobre su salud si está incorrecta o incompleta en nuestros expedientes. Podemos denegar su petición con tal que sea apropiado hacerlo.

El derecho a pedir que las comunicaciones sean confidenciales. Usted tiene el derecho a pedir que le entreguemos la información sobre su salud de una manera específica o en un lugar específico. Debemos aceptar el cumplimiento de una petición razonable o podemos denegar su petición si va en contra de la ley o de nuestras normas.

El derecho a pedir restricciones con respecto a cómo se utiliza o divulga la información sobre su salud. Usted tiene derecho a pedir que la información sobre su salud no se utilice ni se divulgue para ciertos fines. No se nos exige aceptar su petición a menos que se requiera por ley o si usted pide que se restrinja la divulgación de la información protegida sobre su salud al plan de seguro médico con tal que usted pague, en su totalidad, al Presbyterian por esos servicios o los artículos médicos. Deberemos informarle si no podemos aceptar su petición.

El derecho a pedir un informe de las divulgaciones. Usted tiene derecho a solicitar un *Informe de las Divulgaciones*. Ese informe mostrará cuándo divulgamos la información sobre su salud a entidades fuera de nuestra organización sin su autorización escrita.

El derecho a recibir una copia impresa de esta notificación. Usted tiene derecho a recibir una copia impresa de esta notificación, aún si usted aceptó recibirla de forma electrónica.

CUÁNDO SE PUEDE UTILIZAR O DIVULGAR LA INFORMACIÓN SOBRE SU SALUD SIN SU AUTORIZACIÓN POR ESCRITO

Para fines de tratamiento. Utilizamos y divulgamos la información sobre su salud a fin de que nuestros proveedores de servicios médicos le puedan proveer tratamientos médicos.

Para fines de pagos. Utilizamos y divulgamos la información sobre su salud con el fin de recibir pagos por tratamientos o servicios que se le hayan proporcionado o para facilitar los pagos por los mismos.

Para fines de las diligencias de los servicios médicos. Utilizamos y divulgamos la información sobre su salud para poder operar el elemento de negocios de nuestra organización y ofrecerles atención clínica y servicios médicos de alta calidad a nuestros pacientes.

Cuando lo requiera la ley. Utilizaremos y divulgaremos la información sobre su salud cuando así lo requieran las leyes federales, estatales o locales.

Para situaciones de emergencia. Utilizaremos nuestro criterio profesional para decidir si la divulgación de la información sobre su salud es lo mejor para usted en caso de una emergencia médica o si usted se encuentra incapacitado(a).

Para las actividades de salubridad pública. Divulgamos la información sobre su salud a las autoridades de salubridad pública con fines de asegurar el bienestar público.

Para las actividades de supervisión de organizaciones que prestan servicios clínicos. La información sobre su salud se puede divulgar a agencias que tengan autoridad para vigilar nuestras actividades.

Para los procedimientos legales y administrativos. La información sobre su salud se puede divulgar como parte de un procedimiento administrativo o legal.

Para el cumplimiento de la ley. Si así lo pide un funcionario del orden público, podemos divulgar sólo una porción muy limitada de la información sobre su salud.

Para los médicos forenses, los investigadores médicos y los directores de funerarias. La información clínica de una persona fallecida se puede divulgar a los médicos forenses, los investigadores médicos y los directores de funerarias a fin de que puedan llevar a cabo sus obligaciones.

Para la donación de órganos y tejidos. Se puede divulgar la información sobre su salud a organizaciones que obtengan, conservan o trasplantan órganos y tejidos humanos.

Para la seguridad pública. Se puede divulgar la información sobre su salud para prevenir o atenuar un peligro grave y urgente a la salubridad o a la seguridad de una persona específica o del público en general.

Para las diligencias especiales del gobierno. Se puede divulgar la información sobre su salud a funcionarios federales para fines de seguridad nacional conforme a las leyes.

A las instituciones penales. Si usted está preso, la información sobre su salud se puede divulgar al personal de las instituciones penales o a los funcionarios del orden público a fin de proteger su salud, o la salud y la seguridad de los demás.

A la división de compensación laboral. Se puede utilizar o divulgar la información sobre su salud conforme a las leyes de compensación laboral.

Si hay un cambio de propietario. Si el Presbyterian o un integrante del OHCA que participa en esta notificación se vendieran o fusionaran con otra organización, los expedientes que contienen información sobre su salud pasarían a ser propiedad del nuevo dueño.

Al Secretario de Salubridad y Servicios Humanos. Se requiere por ley que divulguemos la información sobre la salud al Secretario del Departamento de Salubridad y Servicios Humanos de los Estados Unidos [U.S. Department of Health and Human Services, HHS] si dicha entidad gubernamental pide la información sobre la salud para verificar si estamos cumpliendo con la ley de la privacidad.

CUÁNDO SE REQUIERE LA AUTORIZACIÓN POR ESCRITO PARA UTILIZAR O DIVULGAR LA INFORMACIÓN SOBRE LA SALUD

No utilizaremos ni divulgaremos la información sobre su salud sin su autorización escrita a menos que se requiera por ley o según se explica en esta *Notificación Conjunta de las Prácticas Referentes a la Privacidad*. Usted puede cancelar una autorización por escrito en cualquier momento, exceptuando el punto hasta el cual hayamos ya tomado acción conforme a dicha autorización.

Para el mercadeo. No utilizamos ni divulgamos la información sobre su salud con fines de mercadeo sin que usted lo autorice por escrito. Hay dos excepciones que se permiten: si conversamos en persona con usted acerca de eso o para darle un regalo de promoción cuyo valor monetario sea mínimo o nulo. Si una actividad de mercadeo requiere que se nos haga un pago directo o indirecto por parte de terceros, la autorización que se le pedirá que firme deberá indicar ese hecho.

Para las investigaciones. Con su autorización por escrito, podemos divulgar la información sobre su salud a los investigadores que estén llevando a cabo estudios aprobados por la Junta de Revisión Institucional del Presbyterian o por otra junta de investigaciones o de privacidad.

La venta de la información protegida sobre su salud. No vendemos a nadie la información sobre su salud.

CUÁNDO SE PERMITE QUE USTED RESTRINJA LA MANERA EN QUE SE UTILIZA O DIVULGA LA INFORMACIÓN SOBRE SU SALUD O PARA OPTAR POR NO PARTICIPAR EN ESAS ACTIVIDADES

En la guía del centro clínico. A menos que usted nos diga que no está de acuerdo, utilizaremos su nombre, su localización en nuestro centro clínico, su estado médico general y su preferencia religiosa como parte de la información que consta en nuestra guía. La información que contiene la guía se puede divulgar a los clérigos de su fe.

Para avisar y comunicarnos con los familiares y otras personas que participen en su atención médica.

A menos que usted nos avise que se opone, podemos divulgar la información sobre su salud a las personas que participen en su atención médica. Si así lo hacemos, sólo podremos divulgar la información que corresponda directamente a la participación de esa persona en su atención médica o para que pague por la misma.

Para las actividades de recuperación en caso de desastre. A menos que usted nos avise que se opone, podemos utilizar y divulgar la información sobre su salud a una organización particular o pública que tenga autoridad legal para ayudar en esfuerzos de recuperación en caso de desastre a fin de avisar a sus familiares acerca de su afección médica, su estado de salud y su localización.

Para las campañas de recaudar fondos. Tal vez nos comuniquemos con usted a fin de recaudar fondos para el Presbyterian. Los fondos que se recauden se utilizan para prestar servicios médicos y para los programas educativos que ofrecemos a la comunidad. Los materiales de la campaña explican cómo usted puede solicitar que no se le envíen ese tipo de materiales en el futuro. Si usted desea conseguir información más detallada sobre eso, consulte la sección de Cómo presentar una petición de esta notificación.

EL PRESBYTERIAN TIENE DERECHO A CAMBIAR ESTA NOTIFICACIÓN DE LAS PRÁCTICAS REFERENTES A LA PRIVACIDAD

El Presbyterian se reserva el derecho a cambiar las prácticas referentes a la privacidad que se explican en esta *Notificación de las Prácticas Referentes a la Privacidad* en cualquier momento. Si cambian los términos de esta notificación, se publicará una nueva notificación y se publicará en nuestros centros clínicos y en nuestro sitio web. Se le proporcionará a usted la nueva notificación si nos la pide y según lo requiera la ley. Los términos que se describan en la nueva notificación se aplican a toda la información sobre la salud que guarda tanto el Presbyterian como todos los integrantes del OHCA que participen en esta notificación. Usted puede obtener una copia electrónica de esta notificación en nuestro sitio web en la dirección: www.phs.org.

OTRAS ENTIDADES QUE PARTICIPAN EN NUESTRO ACUERDO ORGANIZADO DE ATENCIÓN CLÍNICA Y EN NUESTRA NOTIFICACIÓN CONJUNTA [OHCA, las iniciales en inglés]

La ley permite que los integrantes de un Acuerdo Organizado de Atención Clínica [OHCA, las iniciales en inglés] compartan entre sí la información sobre su salud para ciertos fines: para tratamientos, para recibir pagos por servicios que se hayan prestado o para las diligencias de atención médica del OHCA. Los integrantes del OHCA que se enumeran a continuación han aceptado cumplir con las prácticas de privacidad que se describen en esta *Notificación Conjunta de las Prácticas Referentes a la Privacidad*:

- Presbyterian Healthcare Services: todos los centros clínicos
- Todos los centros clínicos y las clínicas que el Presbyterian opera, arrienda o administra
- Los médicos individuales y los grupos de médicos radicados en los hospitales que aceptan, junto con el Presbyterian, cumplir con lo que se establece en esta *Notificación Conjunta de las Prácticas Referentes a la Privacidad*.
- Los servicios de atención médica en casa que ofrece el Presbyterian: todas las divisiones

El Presbyterian también es integrante de un OHCA junto con el Presbyterian Health Plan, Inc. y el Presbyterian Insurance Company, Inc., que tienen sus propias notificaciones.

CÓMO PRESENTAR UNA PETICIÓN: Si usted desea solicitar del Presbyterian una copia de la información sobre su salud, o para pedir una enmienda a la misma, o para pedir un Informe de las Divulgaciones de la información sobre su salud, usted se puede comunicar con Health Information Management [la administración de la información sobre la salud] al (505) 841-1740 o fuera de Albuquerque al 1-866-352-1528. Para pedir que no se le envíen los materiales de recaudación de fondos, comuníquese con el: Presbyterian Healthcare Foundation al (505) 724-6580. Si usted desea presentar una reclamación sobre las prácticas referentes a la privacidad, comuníquese con el funcionario del Presbyterian encargado de las cuestiones de privacidad [Presbyterian Privacy Official] al (505) 923-6176 o con el Secretary of HHS [Secretario del HHS], Office for Civil Rights [la oficina de derechos civiles], Region VI, 1301 Young Street, Suite 1169, Dallas, TX 75202. No se tomarán represalias contra usted por haber presentado una reclamación. Si desea recibir más información, comuníquese con el Presbyterian's Compliance Dept. [Departamento de cumplimiento del Presbyterian] al (505) 923-8544.

Entra en vigor a partir de la fecha de la enmienda: 1º de agosto de 2013

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Presbyterian Senior Care (HMO) Customer Service Center

Method	Presbyterian Customer Service Center – Contact Information
CALL	<p>(505) 923-6060 or 1-800-797-5343. Calls to this number are free.</p> <p>Our business hours are 8 a.m. to 8 p.m., 7 days a week (except holidays) October 1 through March 31. If you are calling from April 1 through September 30, customer service hours are 8 a.m. to 8 p.m., Monday through Friday (except holidays).</p> <p>We also have free language interpreter services available for non-English speakers.</p>
TTY	<p>711. Calls to this number are free.</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Our business hours are Sunday through Saturday, 8 a.m. to 8 p.m., 7 days a week.</p>
FAX	(505) 923-5124
WRITE	<p>Presbyterian Senior Care (HMO) P.O. Box 27489 Albuquerque, NM 87125-7489</p> <p>Email: info@phs.org</p> <p>Please include your first and last name, date of birth, a contact address and phone number, and the details of your inquiry. Presbyterian members should also include their member identification number if available.</p>
WEBSITE	www.phs.org/Medicare

The New Mexico Aging and Long-Term Services Department

The New Mexico Aging and Long-Term Services Department is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-432-2080. Calls to this number are free.
TTY	<p>(505) 476-4937</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p>
WRITE	<p>New Mexico Aging and Long-Term Services Department P.O. Box 27118 Santa Fe, NM 87502-7118</p>
WEBSITE	www.nmaging.state.nm.us