**January 1 – December 31, 2026**

# Evidence of Coverage for 2026:

## Your Medicare Health Benefits and Services as a Member of *Senior Care Plus Patriot Plan (HMO)*.

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

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

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

**For questions about this document, call Customer Service at (888) 775-7003 (TTY users call 711). Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday This call is free.**

If you need care urgently outside of the above hours, please go to your nearest urgent care provider (see page 77 for coverage details). Teladoc is also an option for after hours. To access the platform, please navigate to the following website to register your account, member.teladoc.com/signin. If you have an emergency please call 911 or go to your nearest emergency room or hospital (see page 47 for coverage details).

This plan, *Senior Care Plus Patriot Plan*, is offered by Senior Care Plus. (When this *Evidence of Coverage* says "we," "us," or "our," it means Senior Care Plus. When it says "plan" or "our plan," it means *Senior Care Plus Patriot Plan*.)

This document is available for free in Spanish.

ATENCION: Si usted habla español, servicios de asistencia de idiomas, de forma gratuita, están disponibles para usted. Llame al 1-888-775-7003 (los usuarios de TTY deben llamar al Servicio De Retransmisión del Estado al 711)

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

Please contact Customer Service at 775-982-3112 or toll-free at 888-775-7003 for additional information. (TTY users should call the State Relay Service at 711). (We are not open 7 days a week all year round). Hours are 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

This information is available in different formats, including Spanish and other languages, as well as large print and braille. Customer Service also has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet). Please contact Customer Service at the number listed above if you need plan information in another format or language.

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

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



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

## Table of Contents

**CHAPTER 1: Get started as a member ..... 4**

SECTION 1 You're a member of Senior Care Plus Patriot Plan ..... 4

SECTION 2 Plan eligibility requirements ..... 4

SECTION 3 Important membership material ..... 5

SECTION 4 Summary of Important Costs for 2026 ..... 6

SECTION 5 More information about your monthly plan premium ..... 8

SECTION 6 Keep our plan membership record up to date ..... 8

SECTION 7 How other insurance works with our plan ..... 9

**CHAPTER 2: Phone numbers and resources ..... 11**

SECTION 1 *Senior Care Plus Patriot Plan* contacts ..... 11

SECTION 2 Get help from Medicare ..... 15

SECTION 3 State Health Insurance Assistance Program (SHIP) ..... 16

SECTION 4 Quality Improvement Organization (QIO) ..... 17

SECTION 5 Social Security ..... 18

SECTION 6 Medicaid ..... 18

SECTION 7 Railroad Retirement Board (RRB) ..... 19

SECTION 8 If you have group insurance or other health insurance from an employer ..... 20

**CHAPTER 3: Using our plan for your medical services ..... 21**

SECTION 1 How to get medical care as a member of our plan ..... 21

SECTION 2 Use providers in our plan's network to get medical care ..... 23

SECTION 3 How to get services in an emergency, disaster, or urgent need for care ..... 26

SECTION 4 What if you're billed directly for the full cost of covered services? ..... 28

SECTION 5 Medical services in a clinical research study ..... 28

SECTION 6 Rules for getting care in a religious non-medical health care institution ..... 30

SECTION 7 Rules for ownership of durable medical equipment ..... 31

SECTION 8 How to Submit for Direct Medical Reimbursement ..... 33

**CHAPTER 4: Medical Benefits Chart (what's covered and what you pay) ..... 34**

SECTION 1 Understanding your out-of-pocket costs for covered services .....34
SECTION 2 The Medical Benefits Chart shows your medical benefits and costs .....36
SECTION 3 Services that aren't covered by our plan (exclusions) .....79

**CHAPTER 5: Asking us to pay our share of a bill for covered medical services ..... 82**
SECTION 1 Situations when you should ask us to pay our share for covered services.....82
SECTION 2 How to ask us to pay you back or pay a bill you got .....83
SECTION 3 We'll consider your request for payment and say yes or no.....84

**CHAPTER 6: Your rights and responsibilities ..... 85**
SECTION 1 Our plan must honor your rights and cultural sensitivities.....85
SECTION 2 Your responsibilities as a member of our plan.....90

**CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints) ..... 93**
SECTION 1 What to do if you have a problem or concern .....93
SECTION 2 Where to get more information and personalized help .....93
SECTION 3 Which process to use for your problem.....94
SECTION 4 A guide to coverage decisions and appeals .....94
SECTION 5 Medical care: How to ask for a coverage decision or make an appeal.....97
SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon.....105
SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon .....109
SECTION 8 Taking your appeal to Levels 3, 4 and 5.....113
SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns .....115

**CHAPTER 8: Ending membership in our plan ..... 119**
SECTION 1 Ending your membership in our plan.....119
SECTION 2 When can you end your membership in our plan? .....119
SECTION 3 How to end your membership in our plan .....121
SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan.....122

SECTION 5 *Senior Care Plus Patriot Plan* must end our plan membership in certain situations ....122

**CHAPTER 9: Legal notices ....124**

SECTION 1 Notice about governing law ....124
SECTION 2 Notice about nondiscrimination ....124
SECTION 3 Notice about Medicare Secondary Payer subrogation rights ....124
SECTION 4 Notice about Privacy Practices ....125
SECTION 5 Notice about Assignment ....132
SECTION 6 Notice about Entire Contract ....132
SECTION 7 Notice about Waiver by Agents ....132
SECTION 8 Notice about Plan's Sole Discretion ....132
SECTION 9 Notice about Disclosure ....133
SECTION 10 Notice about Information on Advance Directives ....133
SECTION 11 Notice about Continuity and Coordination of Care ....134
SECTION 12 Notice about Medicare Secondary Payer subrogation rights ....134

**CHAPTER 10: Definitions ....136**

# CHAPTER 1: Get started as a member

## SECTION 1 You're a member of Senior Care Plus Patriot Plan

### Section 1.1 You're enrolled in *Senior Care Plus Patriot Plan*, which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, *Senior Care Plus Patriot Plan*. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

*Senior Care Plus Patriot Plan* is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. *Senior Care Plus Patriot Plan* *doesn't* include Part D drug coverage.

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

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

The contract is in effect for the months you're enrolled in *Senior Care Plus Patriot Plan* between January 1, 2026, and December 31, 2026.

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

Medicare (the Centers for Medicare & Medicaid Services) must approve *Senior Care Plus Patriot Plan* each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

## SECTION 2 Plan eligibility requirements

### Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B

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

### Section 2.2 Plan service area for *Senior Care Plus Patriot Plan*

*Senior Care Plus Patriot Plan* is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Nevada: Carson City, Storey and Washoe

If you move out of our plan's service area, you can't stay a member of this plan. Call contact Customer Service at (888) 775-7003 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

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

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

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify *Senior Care Plus Patriot Plan* if you're not eligible to stay a member of our plan on this basis. *Senior Care Plus Patriot Plan* must disenroll you if you don't meet this requirement.

## SECTION 3 Important membership material

### Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:


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

If our plan membership card is damaged, lost, or stolen, call Customer Service at (888) 775-7003 (TTY users call 711) right away and we'll send you a new card.

### Section 3.2 Provider Directory

The *Provider Directory https://www.seniorcareplus.com/directories/* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Senior Care Plus Patriot Plan authorizes use of out-of-network providers.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at (888) 775-7003 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

## SECTION 4 Summary of Important Costs for 2026

| | **Your Costs in 2026** |
|---|---|
| **Monthly plan premium*** | **$0** |

| | Your Costs in 2026 |
|---|---|
| *Your premium can be higher than this amount. Go to Section 4.1 for details. | |
| **Part B rebate** | **$65** |
| **Maximum out-of-pocket amount**<br>This is the most you'll pay out-of-pocket for covered Part A and Part B services.<br>(Go to Chapter 4 Section 1 for details.) | **$2,750** |
| **Primary care office visits** | **$0 Copay per visit to a preferred PCPs Medicare covered services.**<br>**$10 Copay per visit to all non-preferred PCPs for Medicare covered services.**<br>**$10 Copay per visit to Convenient Care Facilities.** |
| **Specialist office visits** | **$45 Copay per visit** |
| **Inpatient hospital stays** | **Preferred Facility**<br>**$350 Copay (1-4 days)**<br>**Non-Preferred Facility**<br>**$440 Copay (1-5 days)** |

Your costs may include the following:

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

### Section 4.1 Plan premium

You don't pay a separate monthly plan premium for *Senior Care Plus Patriot Plan.*

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

### Section 4.2 Monthly Medicare Part B Premium

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

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

## SECTION 5 More information about your monthly plan premium

### Section 5.1 Our monthly plan premium won't change during the year

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

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

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

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

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

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

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

If any of this information changes, let us know by calling Customer Service at (888) 775-7003 (TTY users call 711) (phone numbers are printed on the back cover of this booklet).

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

## SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at (888) 775-7003 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

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

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

# CHAPTER 2:
# Phone numbers and resources

## SECTION 1 *Senior Care Plus Patriot Plan* contacts

For help with claims, billing, or member card questions, call or write to *Senior Care Plus Patriot Plan* Customer Service at (888) 775-7003 (TTY users call 711). We'll be happy to help you.

| **Customer Service – Contact Information** | |
|---|---|
| **Call** | **Senior Care Plus**: 775-982-3112 or toll-free at 888-775-7003<br><br>Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday<br><br>Customer Service (888) 775-7003 (TTY users call 711) also has free language interpreter services for non-English speakers. |
| **Call** | **Nations Hearing**: Toll-free 1-(877) 200-4189. TTY 711<br>24 hours a day, 7 days a week, 365 days a year.<br>Calls to this number are free. |
| **Call** | **EyeMed:** 1-(866)-723-0513. Monday – Saturday 7:30 am to 11 pm (EST) and Sunday 11:00 am to 8:00 pm (EST). Calls to this number are free. |
| **Call** | **Liberty Dental:** Toll-free 888-442-3193.<br>Calls to this number are free. Monday through Friday 8:00 am – 8:00 pm (PST) |

| Customer Service – Contact Information | |
|---|---|
| **TTY** | State Relay Service - 711<br><br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br><br>Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday |
| **Fax** | 775-982-3741 |
| **Write** | Senior Care Plus<br>10315 Professional Circle<br>Reno, NV 89521<br>E-mail: Customer_Service@hometownhealth.com |
| **Website** | www.seniorcareplus.com |

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

| Coverage Decisions and Appeals for Medical Care – Contact Information | |
|---|---|
| **Call** | **Senior Care Plus:** 775-982-3112 or toll-free at 888-775-7003<br><br>Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday we are not open 7 days a week all year round<br><br>Customer Service also has free language interpreter services available for non-English speakers. |

| Coverage Decisions and Appeals for Medical Care – Contact Information | |
|---|---|
| **TTY** | State Relay Service - 711<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free. (we are not open 7 days a week all year round. Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday |
| **Fax** | 775-982-3741 |
| **Write** | Senior Care Plus<br>10315 Professional Circle<br>Reno, NV 89521<br>E-mail: Customer_Service@hometownhealth.com |
| **Website** | www.seniorcareplus.com |

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

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

| Complaints about Medical Care – Contact Information | |
|---|---|
| **Call** | **Senior Care Plus:** 775-982-3112 or toll-free at 888-775-7003<br>Calls to this number are free. (we are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday<br>Customer Service also has free language interpreter services available for non-English speakers. |

| **Complaints about Medical Care – Contact Information** | |
|---|---|
| **TTY** | State Relay Service - 711<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free. (we are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday |
| **Fax** | 775-982-3741 |
| **Write** | Senior Care Plus<br>10315 Professional Circle<br>Reno, NV 89521<br>E-mail: Customer_Service@hometownhealth.com |
| **Medicare website** | To submit a complaint about *Senior Care Plus Patriot Plan (HMO)* directly to Medicare, go to www.Medicare.gov/my/medicare-complaint. |

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

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

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

| **Payment Requests – Contact Information** | |
|---|---|
| **Call** | **Senior Care Plus**: 775-982-3112 or toll-free at 888-775-7003<br>Calls to this number are free. (We are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday. Customer Service also has free language interpreter services available for non-English speakers. |

| Payment Requests – Contact Information | |
|---|---|
| **TTY** | State Relay Service - 711<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number are free. (We are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday |
| **Fax** | 775-982-3741 |
| **Write** | Senior Care Plus<br>10315 Professional Circle<br>Reno, NV 89521<br>E-mail: Customer_Service@hometownhealth.com |
| **Website** | www.seniorcareplus.com |

## SECTION 2 Get help from Medicare

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

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

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

| **Medicare – Contact Information** | |
|---|---|
| **Chat Live** | Chat live at www.Medicare.gov/talk-to-someone. |
| **Write** | Write to Medicare at PO Box 1270, Lawrence, KS 66044 |
| **Website** | www.Medicare.gov<br>• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.<br>• Find Medicare-participating doctors or other health care providers and suppliers.<br>• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits).<br>• Get Medicare appeals information and forms.<br>• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.<br>• Look up helpful websites and phone numbers.<br>You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Senior Care Plus Patriot Plan.<br>**To submit a complaint to Medicare,** go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. |

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Nevada, the SHIP is called Nevada SHIP (through Nevada Division for Aging Services and Access to Healthcare Network).

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

Nevada SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your

Medicare bills. Nevada SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices and answer questions about switching plans.

| **Nevada SHIP – Contact Information** | |
|---|---|
| **Call** | 1-800-307-4444 or 1-877-385-2345 |
| **TTY** | 1-877-486-2048 (Medicare).<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | State of Nevada Aging and Disability Services Division<br>3416 Goni Road, Suite D-132<br>Carson City, NV 89706 |
| **Website** | adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/ or www.accesstohealthcare.org. |

## SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Commence Health in any of these situations:

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

| **Commence Health (Nevada's Quality Improvement Organization) – Contact Information** | |
|---|---|
| **Call** | 1-877-588-1123 for appeals or for all other reviews.<br>Monday through Friday, 9:00 am – 5:00 pm.<br>Saturday/Sunday and holidays, 10:00 am – 4:00 pm. |

| **Commence Health (Nevada's Quality Improvement Organization) – Contact Information** | |
|---|---|
| **TTY** | 711.<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | BFCC-QIO Program<br>PO BOX 2687<br>Virginia Beach, VA 23450 |

## SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

| **Social Security – Contact Information** | |
|---|---|
| **Call** | 1-800-772-1213<br>Calls to this number are free.<br>Available 8 am to 7 pm, Monday through Friday.<br>Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day. |
| **TTY** | 1-800-325-0778<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free.<br>Available 8 am to 7 pm, Monday through Friday. |
| **Website** | www.SSA.gov |

## SECTION 6 Medicaid

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

Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact Nevada Medicaid.

| **Nevada Department of Health and Human Services – Division of Welfare and Supportive Services – Contact Information** | |
|---|---|
| **Call** | 775-684-0800 or 800-992-0900 (select option 2)<br>Monday through Friday, 8:00 am to 5:00 pm |
| **TTY** | 1-800-326-6888.<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | Nevada Department of Health and Human Services – Division of Welfare and Supportive Services<br>2533 North Carson Street, Suite 200<br>Carson City, NV 89706 |
| **Website** | https://dwss.nv.gov/ |

## SECTION 7 Railroad Retirement Board (RRB)

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

your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at (888) 775-7003 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

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

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

### Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, *Senior Care Plus Patriot Plan* must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

*Senior Care Plus Patriot Plan* will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. *Here are 3 exceptions:*
    - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
    - 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. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

## SECTION 2 Use providers in our plan's network to get medical care

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

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

When you become a member of the Senior Care Plus' Senior Care Plus Patriot Plan, you must choose a plan provider to be your PCP. Your PCP is a person who meets state requirements and is trained to give you basic medical care.

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without contacting your PCP first, except as we explain below. Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your x-rays, laboratory tests, therapies, specialist care, hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other plan providers about your care. You do not need a referral to see a network specialist on the plan.

However, if you need certain types of covered services or supplies, your PCP or Senior Care Plus will give approval in advance. In some cases, your PCP will also need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Be assured that Senior Care Plus is committed to protecting the privacy of your medical records and personal health information.

**How to choose a PCP?**

You select your PCP when you enroll in Senior Care Plus. To select your PCP, please refer to the Senior Care Plus *Provider Directory* or our website at www.SeniorCarePlus.com. You can visit our website or call Customer Service to find out which providers are accepting new patients (which means their panel is open). You can change your PCP at any time, as explained later in this section.

**How to change your PCP**

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

To change your PCP, call Customer Service. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to

switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

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

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Customer Service at (888) 775-7003 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

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

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

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

When your PCP thinks that you need specialized treatment, he/she will not have to give you a referral (approval in advance) to see a plan specialist. However, if you need certain types of covered services or supplies, your PCP will get approval in advance. In some cases, your specialist will also need to get prior authorization (prior approval).

It is very important to get a referral (approval in advance) from your PCP for certain services before you see a plan specialist or certain other providers (there are exceptions, including routine women's health care that we explained in the previous section). Senior Care Plus does not require you to have a referral to see a specialist, however, some specialists may not schedule an appointment for you without a referral from your PCP. If the specialist wants you to come back for more care, check first to be sure that the additional visits to the specialist will be covered.

If there are specific specialists you want to use, find out whether your PCP prefers these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a plan specialist that your current PCP may not refer you to. Refer to Section 2.1 subsection, "Changing your PCP," where we tell you how to change your PCP.

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

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

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

- If you find out your doctor or specialist is leaving our plan, call Customer Service at (888) 775-7003 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

If a specialist, clinic, hospital, or other network provider you are using is leaving the Plan, you will have to switch to another provider who is part of our Plan. Typically, Senior Care Plus will notify you in advance of a provider leaving our network. We will assign you to another provider within our network that is similar in location and practice, as well as guidance on how to select a provider if you do not agree with the assignment. Please contact Customer Service at the telephone number on the cover of this booklet if you would like to select another provider or to inquire on whether a provider is in the network.

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

As a Senior Care Plus member, your plan has a network of healthcare providers available to you. If the healthcare services aren't available within the network, then your provider must contact our Healthcare Utilization Management (Prior authorization) department to request a review for an out-of-network provider. Our determination will be sent to you and your provider.

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

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

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

If you have a medical emergency:

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

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

- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Our telephone numbers are on your membership card.

**Covered services in a medical emergency**

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

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

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

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

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

provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan offers worldwide emergency services outside the United States when medically necessary. For more information about worldwide emergency care coverage, see the Medical Benefits Chart in Chapter 4 of this booklet.

### Section 3.3 Get care during a disaster

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

Visit www.seniorcareplus.com for information on how to get needed care during a disaster.

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

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

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

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

*Senior Care Plus Patriot Plan* covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward an out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

## SECTION 5 Medical services in a clinical research study

### Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research

studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

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

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

Like Inpatient Hospital coverage limits, if authorized, you have unlimited coverage for this benefit. For more information, see the Medical Benefits Chart in Chapter 4 of this Booklet.

## SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of *Senior Care Plus Patriot Plan*, however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of

the DME item to you. Call Customer Service at (888) 775-7003 (TTY users call 711) (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

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

If you qualify for Medicare oxygen equipment coverage, Senior Care Plus Patriot Plan will cover:

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

If you leave Senior Care Plus Patriot Plan or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this

point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

## SECTION 8 How to Submit for Direct Medical Reimbursement

Member reimbursement forms are available for direct reimbursement for services rendered at an office for Urgent or Emergent services. Urgent or Emergent care services are reimbursable at the current Medicare rate incurred inside the United States. Emergencies or Urgent Care inside of the United States must have the applicable Member Reimbursement form filled out with the member information, CPT and diagnosis codes and evidence of payment to the Provider.

Claims incurred outside the United States for Emergency treatment of a Member must have medical records or itemized superbill. Bills that are not itemized for services rendered will not be reimbursed. This needs to be submitted with the Member Reimbursement form filled out with member information as well. If requested documents are not signed and returned to us or our representative within 90 days of the request, we will no longer have any obligation to pay any covered expense incurred by the member.

The Member Reimbursement form can be found at Claim form (hometownhealth.com). Once the form is completed you can fax it to our Reimbursement Services Department at 775-982-3751, email it to customer_service@hometownhealth.com or mail it to our office located at:

Hometown Health

10315 Professional Circle

Reno, NV 89521

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

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of *Senior Care Plus Patriot Plan*. This section also gives information about medical services that aren't covered and explains limits on certain services.

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

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

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

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

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

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $2,750.**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. If you reach the maximum out-of-

pocket amount of $2,750, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our 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 get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Customer Service at (888) 775-7003 (TTY users call 711).

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

The Medical Benefits Chart on the next pages lists the services *Senior Care Plus Patriot Plan* covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

## Medical Benefits Chart

| Covered Service | What you pay |
|---|---|
| **Abdominal aortic aneurysm screening**<br>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors 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**<br>Covered services include:<br>Up to 12 visits in 90 days are covered under the following circumstances:<br>For the purpose of this benefit, chronic low back pain is defined as:<br>• Lasting 12 weeks or longer;<br>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.);<br>• not associated with surgery; and<br>• not associated with pregnancy.<br>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br>Treatment must be discontinued if the patient is not improving or is regressing.<br>**Provider Requirements:**<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.<br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: | **$30** copay per visit |

| Covered Service | What you pay |
|---|---|
| • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.<br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.<br>*Maximum of 20 visits per plan year* | |
| **Ambulance services**<br>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. | **$250** copay for each one-way Medicare-covered ambulance ground or air trip.<br>**$0** copay for transportation between inpatient facilities.<br>According to Medicare guidelines, emergency and non-emergency ambulance services are covered based on medical necessity. If your condition qualifies for coverage, you will pay the copayment listed above.<br>If your condition does not meet Medicare criteria and you utilize the ambulance service, you will then be responsible for the entire cost. |
| **Annual physical exam** | You pay **$0** copay for an annual physical. If you |

| Covered Service | What you pay |
|---|---|
| An examination performed by a primary care physician. This is covered once every 12 months. Services include:<br>• An age and gender appropriate physical exam, including vital signs and measurements.<br>• Guidance, counseling and risk factor reduction interventions.<br>• Administration or ordering of immunization, lab tests or diagnostic procedures. | receive services that address a medical condition during the same office visit, additional cost-share may apply |
| **Annual wellness visit**<br>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.<br>**Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months. | There is no coinsurance, copayment, or deductible for the annual wellness visit. |
| **Bone mass measurement**<br>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. | There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. |
| **Breast cancer screening (mammograms)**<br>Covered services include:<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for women aged 40 and older<br>• Clinical breast exams once every 24 months<br>A screening mammography is used for the early detection of breast cancer in women who have no signs or symptoms of the disease. Once a history of breast cancer has been established, | There is no coinsurance, copayment, or deductible for covered screening mammograms.<br>You are covered for an unlimited number of screening mammograms when medically necessary. |

| Covered Service | What you pay |
|---|---|
| and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefits is not available for members who have signs or symptoms of breast cancer.<br>*You may get this service on your own, without a referral from your PCP as long as you get it from a Plan provider.* | **$10** copay office visit copay may apply if the service is not considered preventative or if the member is outside of the age limit (40+) or usage limit (1 per 12 months). |
| **Cardiac rehabilitation services**<br>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral.<br>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | **$10** copay for Medicare-covered Intensive Cardiac Rehabilitation Services.<br>**$15** copay for Medicare-covered Cardiac Rehabilitation Services. |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**<br>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. | There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.<br>**$10** copay office visit copay may apply if the services are not considered preventative. |
| **Cardiovascular disease screening tests**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.<br>**$10** copay office visit copay may apply if the services are not considered preventative |

| Covered Service | What you pay |
|---|---|
| | or if the member goes over the usage limit (once every 5 years). |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• For all women: Pap tests and pelvic exams are covered once every 24 months<br>• If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months<br>*You may get these routine women's health services on your own, without a referral from your PCP as long as you get the services from a Plan provider.* | There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.<br>**$10** copay office visit copay may apply if the services are not considered preventative or if the member goes over the usage limit (once every 24months). |
| **Chiropractic services**<br>Covered services include:<br>• We cover only Manual manipulation of the spine to correct subluxation | **$20** copay for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). |
| **Chronic pain management and treatment services**<br>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. | Cost sharing for this service will vary depending on individual services provided under the course of treatment.<br>**$0** copay for each Preferred PCP visit for Chronic Pain Management.<br>**$10** copay for each non-Preferred PCP visit for Chronic Pain Management. |

| Covered Service | What you pay |
|---|---|
| | **$45** copay for each specialist visit for Chronic Pain Management. |
| **Colorectal cancer screening**<br>The following screening tests are covered:<br>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.<br>• Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.<br>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography.<br>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non- | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam<br>A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost sharing described later in this chart. |

| Covered Service | What you pay |
|---|---|
| invasive stool-based colorectal cancer screening test returns a positive result.<br>• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.<br>**Note:** If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the outpatient surgery cost sharing in this chart. Therefore, the screening colonoscopy benefit is not available for members who have signs or symptoms prior to the colonoscopy. | |
| **Dental services**<br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:<br>• Preventive dental services<br>o Oral exams<br>o Cleanings<br>• Diagnostic dental services<br>o Dental x-rays<br>• Comprehensive dental services<br>o Non-routine services<br>o Restorative services<br>o Endodontics services | **Non-Medicare covered preventive and diagnostic dental services:**<br>• Oral exams: **$0** copay*<br>• Cleanings: **$0** copay*<br>• Fluoride treatments: Not covered<br>• Dental x-rays: **$0** copay*<br>**Non-Medicare covered comprehensive dental services:**<br>• Non-routine services: **$0** copay*<br>• Restorative services: **$0** copay* |

| Covered Service | What you pay |
|---|---|
| ○ Periodontics services<br>○ Extractions<br>○ Prosthodontic and oral/maxillofacial services<br><br>**Diagnostic and Preventive Services** do not apply to your dental coverage limit.<br><br>**Comprehensive Dental Services:** Plan pays up to **$1,500** every year for non-Medicare covered comprehensive dental services. You are responsible for any amount above the dental coverage limit.<br><br>Our plan partners with LIBERTY Dental Plan to provide your dental benefits. To locate a network provider, you may call Customer Service at (888) 442-3193 or search the LIBERTY Dental Plan online provider directory at www.libertydentalplan.com/SCP. If you choose to use a provider outside of the network, the services you receive will not be covered.<br><br>Fees are based on contracted fees for in-network dentists. Reimbursement is paid on LIBERTY Dental Plan's contract allowances and not necessarily the dentist's actual fees. | • Endodontics: **$0** copay*<br>• Periodontal services: **$0** copay*<br>• Extractions: **$0** copay*<br>• Prosthodontic and oral/maxillofacial services: **$0** copay*<br><br>*Frequencies and Limitation Apply<br><br>Some services are subject to review to determine if they are necessary and appropriate based upon industry standards and Liberty clinical guideline<br><br>For a complete list of covered benefits and frequencies please visit SeniorCarePlus.com |
| **Depression screening**<br><br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | There is no coinsurance, copayment, or deductible for an annual depression screening visit.<br><br>**$10** copay office visit copay may apply if the service is not considered preventative or if the member goes over the usage limit (one screening per year). |

| Covered Service | What you pay |
|---|---|
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.<br>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test. | There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. |
| **Diabetes self-management training, diabetic services, and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<br>• Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.<br>• For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.<br>• Diabetes self-management training is covered under certain conditions.<br>*Orthopedic and Orthotic devices require prior-authorization(approval in advance) to be covered.* | There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.<br>There is no cost for blood glucose monitors.<br>**20%** coinsurance of the cost for each Medicare-covered Diabetes supply item received in a retail setting or through mail order |
| **Durable medical equipment (DME) and related supplies**<br>(For a definition of durable medical equipment, go to Chapter 10 and Chapter 3)<br>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, | **20%** coinsurance of the cost for each Medicare-covered item |

| Covered Service | What you pay |
|---|---|
| hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.<br><br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.SeniorCarePlus.com<br><br>Generally, the *Senior Care Plus Patriot Plan (HMO)* Plan covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to the *Senior Care Plus Patriot Plan (HMO)* Plan and using a brand of DME not on our list, we'll 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 after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)<br><br>If you (or your provider) don't agree with our plan's coverage decision, you or your provider can 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, go to Chapter 7.) | Prior authorization rules may apply if the cost is over **$500** |
| **Emergency care**<br><br>Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services, and<br>• Needed to evaluate or stabilize an emergency medical condition.<br><br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a | **$140** copay for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital within 24 hours. If you are admitted to a hospital, you will pay cost sharing as described in the "Inpatient Hospital |

| Covered Service | What you pay |
|---|---|
| limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.<br><br>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.<br><br>Coverage is available worldwide with a **$10,000** annual maximum. | Care" section in this benefit chart. If you are held for observation, the **Outpatient Observation** copayment applies<br><br>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the same cost sharing you would pay at a network hospital.<br><br>In some cases, you may have to pay an additional copayment for the services provided by certain providers in the emergency room |
| **Fitness Benefit**<br><br>Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Patriot (HMO) Plan. Please visit www.SeniorCarePlus.com for information on signing up for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year. | There is no coinsurance, copayment, or deductible for members eligible for the fitness benefit. |
| **Health and wellness education programs**<br><br>Senior Care Plus offers written health education materials, including newsletters, as well as services of a certified health educator or other qualified health professional. We offer a number of educational and support programs for members to overcome the challenges presented through health conditions | There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs |

| Covered Service | What you pay |
|---|---|
| such as asthma or diabetes and to aid them in creating and adopting a healthy lifestyle.<br><br>Nutrition and weight management services are offered by registered dieticians in the form of nutrition counseling (non-diabetes) and weight management courses. Nutrition education has no limit to the number of visits as long as medical necessity is met. Services may be in a group or individual setting, but generally one-on-one counseling. | |
| **Hearing services**<br><br>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.<br>In addition to Medicare-covered benefits, we also cover the following through NationsHearing:<br><br>• Routine hearing exams: one exam every year<br>• Hearing aids: up to **$400** toward the cost of up to two hearing aids from Nations Hearing every benefit period. You are responsible for any remaining cost after the plan's benefit maximum is applied.<br>• Hearing aid fitting evaluations: one hearing aid fitting/evaluation every year<br><br>Hearing aid purchases include:<br>• 3 follow-up visits within the plan year.<br>• 60-day trial period from date of fitting<br>• 60 batteries per year per hearing aid (3-year supply)<br>• 3-year manufacturer repair warranty<br>• 1-time replacement coverage for lost, stolen or damaged hearing aid (deductible may apply per aid)<br>• First set of ear molds (when needed)<br><br>Our plan has partnered with NationsHearing to provide your non-Medicare-covered hearing services. You must obtain your hearing aids through NationsHearing. Please contact NationsHearing by phone at **(877) 200-4189 (TTY:711)** for more information or to schedule an appointment. | Medicare-covered hearing exams: **$50** copay<br><br>Routine hearing exam: **$0** copay<br><br>Hearing aid fitting evaluation: **$0** copay<br><br>Hearing aid pricing varies based on the technology level selected. |

| Covered Service | What you pay |
|---|---|
| **HIV screening**<br>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:<br>• One screening exam every 12 months<br>If you are pregnant, we cover:<br>• Up to 3 screening exams during a pregnancy | There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. |
| **Home health agency care**<br>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but aren't limited to:<br>• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies | There is no coinsurance, copayment, or deductible for members eligible for home health agency care.<br>Prior authorization rules may apply. |
| **Home infusion therapy**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).<br>Covered services include, but aren't limited to:<br>• Professional services, including nursing services, furnished in accordance with our plan of care<br>• Patient training and education not otherwise covered under the durable medical equipment benefit<br>• Remote monitoring | **20%** coinsurance for Medicare-covered Home Infusion Therapy Services |

| Covered Service | What you pay |
|---|---|
| • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | |
| **Hospice care**<br>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br>Covered services include:<br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care<br><br>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.<br>**For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.<br>**For services covered by Medicare Part A or B not related to your terminal prognosis**: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). | When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not the Senior Care Plus Patriot (HMO) Plan.<br>**$45** copay for each specialist visit for hospice consultation services |

| Covered Service | What you pay |
|---|---|
| • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services<br>• If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare<br><br>**For services covered by *Senior Care Plus Patriot Plan* but not covered by Medicare Part A or B:** *Senior Care Plus Patriot Plan* will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.<br><br>**Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.<br><br>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | |
| **Immunizations**<br><br>Covered Medicare Part B services include:<br>• Pneumonia vaccines<br>• Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary<br>• Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B<br>• COVID-19 vaccines<br>• Other vaccines if you're at risk and they meet Medicare Part B coverage rules<br><br>We also cover some vaccines under our Part D prescription drug benefit. See chapter 6 for more information about coverage and applicable cost sharing.<br><br>*Other vaccines require prior-authorization (approval in advance)* | There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. |
| **Inpatient hospital care**<br><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted | **Preferred:**<br><br>**$350** copay per day for day(s) 1–4 |

| Covered Service | What you pay |
|---|---|
| to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.<br><br>Covered services include but aren't limited to:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals including special diets<br>• Regular nursing services<br>• Costs of special care units (such as intensive care or coronary care units)<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Necessary surgical and medical supplies<br>• Use of appliances, such as wheelchairs<br>• Operating and recovery room costs<br>• Physical, occupational, and speech language therapy<br>• Inpatient substance abuse services<br>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. 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. Senior Care Plus provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion.<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint.<br>• Physician services | **$0** copay each day for day(s) 5- 90 for a Medicare-covered stay at a network hospital.<br><br>Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.<br><br>Please refer to the online Provider Directory at www.seniorcareplus.com for a list of Preferred Facilities, please note that our providers may change. You may also call Customer Service at 775-982-3112<br><br>**Non-Preferred:**<br><br>**$440** copay per day for day(s) 1–5<br><br>**$0** copay each day for day(s) 6- 90 for a Medicare-covered stay at a network hospital.<br><br>Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.<br><br>For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. |

| Covered Service | What you pay |
|---|---|
| **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.<br><br>Get more information Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.<br><br>*Except in an emergency, your provider must obtain prior-authorization (approval in advance) to be covered.*<br><br>*Transplant services to include the evaluation process requires prior-authorization (approval in advance) to be covered.* | A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.<br><br>There are no additional copayments for inpatient hospital-acute services when readmitted to a contracted facility during a benefit period or within 60 days of last discharge.<br><br>A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.<br><br>You may pay up to the maximum inpatient |

| Covered Service | What you pay |
|---|---|
| | copayment for each benefit period<br><br>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost-sharing you would pay at a network hospital. |
| **Inpatient services in a psychiatric hospital**<br><br>• Covered services include mental health care services that require a hospital stay here is a 190-day lifetime limit for inpatient services in a free-standing psychiatric hospital<br>• The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.<br><br>There is a 190-day lifetime limit for mental health care and substance abuse services provided in a free standing psychiatric hospital. The benefit is limited by prior partial or complete use of a 190-day lifetime treatment in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.<br>*Except in an emergency, your provider must obtain authorization (approval in advance) to be covered.*<br>*Transplant services to include the evaluation process requires prior-authorization (approval in advance) to be covered* | **Preferred:**<br><br>**$350** copay per day for day(s) 1–4<br><br>**$0** copay each day for day(s) 5–90 for a Medicare-covered stay at a network hospital.<br><br>Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.<br><br>Please refer to the online Provider Directory at www.seniorcareplus.com for a list of Preferred Facilities, please note that our providers may change. You may also call Customer Service at 775-982-3112.<br><br>**Non-Preferred:**<br><br>**$440** copay per day for day(s) 1–5 |

| Covered Service | What you pay |
|---|---|
| | **$0** copay each day for day(s) 6–90 for a Medicare-covered stay at a network hospital.<br><br>Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.<br><br>The 190-day life time limit does not apply to stays in a general acute care hospital.<br><br>There are no additional copayments for inpatient hospital-acute services when readmitted to a contracted facility during a benefit period or within 60 days of last discharge.<br><br>A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. |

| Covered Service | What you pay |
|---|---|
| | You may pay up to the maximum inpatient copayment for each benefit period |
| **Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay**<br>If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:<br>• Physician services<br>• Diagnostic tests (like lab tests)<br>• X-ray, radium, and isotope therapy including technician materials and services<br>• Surgical dressings<br>• Splints, casts, and other devices used to reduce fractures and dislocations<br>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices<br>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition<br>• Physical therapy, speech therapy, and occupational therapy<br>*Physical therapy, speech therapy and occupational therapy over20 visits per year requires prior-authorization (approval in advance) to be covered* | Covered "Part B" services are covered in the same manner as they would be covered if provided in an outpatient setting<br>When your stay is no longer covered, these services will be covered as described in the following sections:<br>Please refer below to Physician/Practitioner Services, Including Doctor's Office Visits.<br>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.<br>Please refer below to Prosthetic Devices and Related Supplies.<br>Please refer below to Outpatient Rehabilitation Services. |
| **Medical nutrition therapy**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered |

| Covered Service | What you pay |
|---|---|
| We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year. | medical nutrition therapy services. |
| **Medicare Diabetes Prevention Program (MDPP)**<br>MDPP services are covered for eligible people under all Medicare health plans.<br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. | There is no coinsurance, copayment, or deductible for the MDPP benefit. |
| **Medicare Part B drugs**<br>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:<br>• Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services<br>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)<br>• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan<br>• The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment.<br>• Clotting factors you give yourself by injection if you have hemophilia | **20%** coinsurance or all drugs covered under Original Medicare.<br>There is no benefit limit on drugs covered under original Medicare.<br>Additionally, for the administration of that drug, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Hospital Services" in this benefit |

| Covered Service | What you pay |
|---|---|
| • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs.<br>• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug<br>• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision<br>• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug.<br>• Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug<br>• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B<br>• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics<br>• Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epoetin beta) | chart) depending on where you received drug administration or infusion services. You pay these amounts until you reach the Medical out-of-pocket maximum<br><br>These prescription drugs are covered under Part B and not covered under the Medicare Prescription Drug Program (Part D) and therefore do not apply to your Medicare Part D out- of-pocket maximum. |

| Covered Service | What you pay |
|---|---|
| • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>• Parenteral and enteral nutrition (intravenous and tube feeding)<br><br>We also cover some vaccines under our Part B drug benefit. | |
| **Obesity screening and therapy to promote sustained weight loss**<br><br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. | There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. |
| **Opioid treatment program services**<br><br>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications<br>• Dispensing and administration of MAT medications (if applicable)<br>• Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br>• Intake activities<br>• Periodic assessments | **$50** copay for each Medicare-covered Opioid Treatment Program Service |
| **Outpatient diagnostic tests and therapeutic services and supplies**<br><br>Covered services include, but aren't limited to:<br>• X-rays<br>• Radiation (radium and isotope) therapy including technician materials and supplies<br>• Surgical supplies, such as dressings<br>• Splints, casts, and other devices used to reduce fractures and dislocations<br>• Laboratory tests | You pay a **$60** copay for Medicare-covered X-rays. You will only pay one copayment per day even if multiple X-rays are performed<br><br>You pay a **$80** copay for Medicare-covered Radiation Therapy visits. |

| Covered Service | What you pay |
|---|---|
| • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used<br>• Other outpatient diagnostic tests - Non-radiological diagnostic services including but not limited to, Sleep Studies, EKGs, Vascular Studies, Stress Tests, and Breathing Capacity Tests.<br>• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.<br>• Other outpatient diagnostic tests – Radiological diagnostic services, not including x-rays, including but not limited to, Ultrasounds, Nuclear Cardiac Imaging, PET, and MRI.<br>• CT Scans<br><br>**Note:** there is no separate charge for medical supplies routinely used in the course of an office visit (such as bandages, cotton swabs and other routine supplies.) However, supplies for which and appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown<br><br>If diagnostic services are performed in the office, the greater of an office visit copayment or diagnostic service copayment will apply. If multiple diagnostic tests are performed on the same day by the same provider, only one copayment will be charged. Facility copayment applies for diagnostic tests performed in a Same-Day Surgery (SDS) facility or Ambulatory Surgery Center (ASC).<br><br>*Radiation Therapy requires prior-authorization (approval in advance) to be covered.* | You pay **$60** copay for Medicare-covered surgical supplies.<br><br>Your copayments for Bone Marrow Services will vary depending on the type and site of service.<br><br>You pay **$0** copay for Medicare-covered laboratory services. This copayment does not apply to blood draws or INR testing (anti-coagulant testing).<br><br>You pay a **$325** copay for Medicare-covered Sleep Studies and Stress Tests.<br><br>You pay **$95** copay for Medicare-covered CT Scans, Vascular Studies and Breathing Capacity Tests.<br><br>You pay a **$130** copay for MRI's, PET Scans, and Nuclear Medicine.<br><br>You pay a **$120** copay for INR Test Strips and Specialty Genetic Testing.<br><br>You pay **$0** copay for Medicare-covered blood services.<br><br>You pay **$45** copay for EKGs, you pay $0 for Pre-Operative EKGs.<br><br>You will only pay one copayment per day even |

| Covered Service | What you pay |
|---|---|
| | if multiple tests are performed. If you have multiple services performed by different providers, separate cost-sharing will apply.<br><br>You pay a **$325** copay for non-preventative flexible sigmoidoscopies that are performed during an outpatient visit.<br><br>You pay **$0** copay for Bone Mineral Density, Retinal Scan, Spiromenty, DPN and Quantiflo testing |
| **Outpatient hospital observation**<br><br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.<br>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.<br>Get more information Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. | **Preferred:**<br><br>**$350** copay for each Medicare-covered Outpatient Hospital Observation services.<br><br>Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.<br><br>Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also call Customer Service at 775-982-3112. |

| Covered Service | What you pay |
|---|---|
| | **Non-Preferred:**<br>**$440** copay for each Medicare-covered Outpatient Hospital Observation services.<br>Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount |
| **Outpatient hospital services**<br>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br>Covered services include, but aren't limited to:<br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery<br>• Laboratory and diagnostic tests billed by the hospital<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it<br>• X-rays and other radiology services billed by the hospital<br>• Medical supplies such as splints and casts<br>• Certain drugs and biologicals you can't give yourself<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.<br>*Requires prior-authorization (approval in advance) to be covered.* | **Preferred:**<br>**$325** copay for each Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility for hospital services.<br>Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.<br>Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also call Customer Service at 775-982-3112<br>**Non-Preferred:**<br>**$440** copay for each Medicare-covered visit to |

| Covered Service | What you pay |
|---|---|
| | an ambulatory surgical center or outpatient hospital facility for hospital services.<br><br>Non-Preferred facilities are in-network facilities that provide these services at a higher copayment amount.<br><br>Biopsy, exploration and removal of foreign bodies and or polyps when undergoing a preventative colonoscopy have a copay of **$0.** Copayment for outpatient surgery or procedures done in a SDS facility will take the Preferred or Non-Preferred copay. If non-preventive Colonoscopies and endoscopies are performed during a visit, the corresponding Preferred or Non-Preferred Outpatient Services copayment applies. |
| **Outpatient mental health care**<br><br>Covered services include:<br>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. | **$45** copay for each Medicare-covered individual/group therapy visit. |

| Covered Service | What you pay |
|---|---|
| **Outpatient rehabilitation services**<br>Covered services include physical therapy, occupational therapy, and speech language therapy.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | **$20** copay or each Medicare-covered physical therapy, occupational therapy, and speech language therapy visit.<br>**$20** copay or each CORF visit.<br>Prior authorization rules may apply. |
| **Outpatient substance use disorder services**<br>Covered services include:<br>Substance use disorder services provided from a Medicare-participating provider or facility as allowed under applicable state laws for treatment of alcoholism and drug abuse in an outpatient setting if services are medically necessary.<br>Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.<br>The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. | **$40** copay for each Medicare-covered individual/group therapy visit |
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**<br>**Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. | **Preferred:**<br>You pay **$325** copay per visit for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or |

| Covered Service | What you pay |
|---|---|
| | ambulatory surgical center.<br><br>Preferred facilities are facilities that provide inpatient, outpatient, and ambulatory services to members for a lower copayment than other in-network facilities.<br><br>Please refer to the online Provider Directory at www.SeniorCarePlus.com for a list of Preferred Facilities, please note that our providers may change. You may also call Customer Service at 775-982-3112.<br><br>**Non-Preferred:**<br><br>You pay **$440** copay per visit for outpatient procedures and services, including but not limited to diagnostic and therapeutic endoscopy, and outpatient surgery performed in an outpatient hospital or ambulatory surgical center.<br><br>Prior authorization rules may apply. |
| **Over-the-counter (OTC) drugs and supplies**<br><br>Your coverage includes OTC items, medications and products.<br><br>You can order:<br><br>• Online – visit SeniorCarePlus.nationsbenefits.com | You have **$25** copay allowance every quarter to spend on plan-approved OTC items, |

| Covered Service | What you pay |
|---|---|
| • By Phone – call a NationsBenefits Member Experience Advisor at **(877) 200-4189 (TTY: 711)**, 24 hours a day, seven days a week, 365 days a year.<br>• By Mail – Fill out and return the order form in the NationsBenefits/Senior Care Plus product catalog. | medications, and products.<br>If you do not use all your quarterly OTC benefit amount when you order, the remaining balance will not accumulate to the next OTC benefit period. |
| **Partial hospitalization services and Intensive outpatient services**<br>*Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.<br>*Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. | **$130** copay for each Medicare-covered visit.<br>**$75** copay for each Medicare-covered Intensive outpatient visit. |
| **Physician/Practitioner services, including doctor's office visits**<br>Covered services include:<br>• Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>• Consultation, diagnosis, and treatment by a specialist<br>• Basic hearing and balance exams performed by your PCP specialist, if your doctor orders it to see if you need medical treatment | **$0** copay per visit to preferred PCPs for Medicare-covered services.<br>**$10** copay per visit for non-preferred PCP's for Medicare Covered services<br>**$10** copay per visit to Convenient Care Facilities. |

| Covered Service | What you pay |
|---|---|
| • Monitoring services in a physicians office or outpatient hospital setting if you are taking anticoagulation medications such as Coumadin, Heparin, or Warfarin (these services may also be referred to as "Coumadin Clinic" services<br>• Certain additional telehealth services, including those for consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare.<br>• Certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. Specific Part B service(s) our plan has identified as clinically appropriate to furnish through electronic exchange when the provider is not in the same location as the enrollee.<br>• Certain additional telehealth services, including for: Dermatology and Urgent Care are provided through Senior Care Plus' Preferred Virtual Visit vendor, Teladoc.<br>  o You have the option of getting through in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.<br>• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>  o You have an in-person visit within 6 months prior to your first telehealth visit<br>  o You have an in-person visit every 12 months while getting these telehealth services<br>  o Exceptions can be made to the above for certain circumstances | **$45** copay for each specialist visit for Medicare-covered services.<br><br>**$0** copay for Dermatology Services provided Senior Care Plus's preferred Virtual Visit vendor, Teladoc.<br><br>No referral is required from your PCP to visit a specialist on the plan.<br><br>If diagnostic services are performed in the office, the greater of an office visit copay or diagnostic service copay will apply. |

| Covered Service | What you pay |
|---|---|
| • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:<br>o You're not a new patient **and**<br>o The check-in isn't related to an office visit in the past 7 days **and**<br>o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:<br>o You're not a new patient **and**<br>o The evaluation isn't related to an office visit in the past 7 days **and**<br>o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Consultation your doctor has with other doctors by phone, internet, or electronic health record<br>• Second opinion by another network provider prior to surgery<br>Teladoc is Senior Care Plus' preferred Virtual Visit vendor. To access the platform, please navigate to the following website, member.teladoc.com/signin to register your account. You may also call Customer Service or Teladoc directly, 1-800-835-2362,for more information on how to use these services. No prior authorization required for Teladoc | |
| **Podiatry services**<br>Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs | **$45** copay for each Medicare-covered visit in an office or home setting. For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient |

| Covered Service | What you pay |
|---|---|
| | Facilities and Ambulatory Surgical Centers |
| **Pre-exposure prophylaxis (PrEP) for HIV prevention**<br>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.<br>If you qualify, covered services include:<br>• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.<br>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.<br>• Up to 8 HIV screenings every 12 months.<br>A one-time hepatitis B virus screening. | There is no coinsurance, copayment, or deductible for the PrEP benefit. |
| **Prostate cancer screening exams**<br>For men aged 50 and older, covered services include the following once every 12 months:<br>• Digital rectal exam<br>• Prostate Specific Antigen (PSA) test | There is no coinsurance, copayment, or deductible for an annual PSA test.<br>**$10** copay office visit copay may apply if the services are not considered preventative or if the member goes over the usage limit (once every 12months). |
| **Prosthetic and orthotic devices and related supplies**<br>Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or | **20%** coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies.<br>**$45** copay for pacemaker checks |

| Covered Service | What you pay |
|---|---|
| replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. | **20%** coinsurance for Medicare-covered medical supplies. |
| **Pulmonary rehabilitation services**<br>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | **$15** copay or Medicare-covered Pulmonary Rehabilitation Services. |
| **Rewards Benefit**<br>You may use your rewards benefit on the prepaid Healthy Rewards Mastercard® Prepaid Card. Earn up to $400 in rewards allowance per year. Rewards are available to enrollees that complete specific health related activities during the calendar year based on eligibility criteria. Health related activities may include, but are not limited to:<br>• Comprehensive Health Assessment<br>• Medicare Health Risk Assessment (DSNP)<br>• Breast Cancer Screening<br>• Colorectal Cancer Screening<br>• Diabetic Retinal Eye Exam<br>• Diabetic Hemoglobin A1c<br>Your benefit dollars can be spent at participating retail locations. For a comprehensive list of participating retailers and eligible products, please visit SeniorCarePlus.nationsbenefits.com. Reward dollars can be redeemed at any time as long as you are an active Senior Care Plus Member.<br>This benefit is not a replacement for your current standalone benefits and is designed to reward members for taking an active role in your health. The Rewards benefit is only for your personal use, cannot be sold or transferred, and has no cash | There is no Copayment or coinsurance for the Healthy Rewards program.<br>*Office or diagnostic copays may apply.* |

| Covered Service | What you pay |
|---|---|
| value. Rewards cannot be used for the purchase of alcohol, tobacco, or firearms.<br><br>You will receive your card once you have completed your first eligible activity.<br><br>You card must be activated before you use your benefits. You can activate your card at SeniorCarePlus.nationsbenefits.com/activate.<br><br>To learn more about this benefit, you can call a Member Experience Advisor at **877 200-4189 (TTY:711)**, 24 hours a day, 7 days a week, 365 days a year.<br><br>You may also find more information on SeniorCarePlus.com. | |
| **Screening and counseling to reduce alcohol misuse**<br><br>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.<br><br>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. |
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br><br>For qualified people, a LDCT is covered every 12 months.<br><br>**Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.<br><br>*For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit | There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. |

| Covered Service | What you pay |
|---|---|
| with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | |
| **Screening for Hepatitis C Virus infection**<br>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:<br>• You're at high risk because you use or have used illicit injection drugs.<br>• You had a blood transfusion before 1992.<br>• You were born between 1945-1965.<br>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.<br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |
| **Services to treat kidney disease**<br>Covered services include: | **20%** coinsurance of the cost for Medicare-covered renal dialysis services. |

| Covered Service | What you pay |
|---|---|
| • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime<br>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)<br>• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)<br>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)<br>• Home dialysis equipment and supplies<br>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)<br><br>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. | Dialysis treatments while you are an inpatient are included in your inpatient hospital care copayment |
| **Skilled nursing facility (SNF) care**<br><br>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)<br><br>Covered services include but aren't limited to:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy and speech therapy<br>• Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)<br>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All | **$20** copay each day for day(s) 1-20<br><br>**$200** copay each day for day(s) 21–34<br><br>**$0** copay each day for days 35–100 for a stay at a Skilled Nursing Facility.<br><br>No prior hospital stay is required.<br><br>You are covered for 100 days each benefit period.<br><br>A benefit period begins on the first day you go to a Medicare covered inpatient hospital or a |

| Covered Service | What you pay |
|---|---|
| other components of blood are covered beginning with the first pint used.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs<br>• X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br><br>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.<br>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)<br>• A SNF where your spouse or domestic partner is living at the time you leave the hospital<br><br>*Requires prior-authorization (approval in advance) to be covered.* | skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br><br>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:<br>• Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease<br>• Are competent and alert during counseling<br>• A qualified physician or other Medicare-recognized practitioner provides counseling<br><br>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. |
| **Supervised Exercise Therapy (SET)** | **$30** copay for Medicare-covered Supervised Exercise Therapy (SET). |

| Covered Service | What you pay |
|---|---|
| SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.<br><br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br><br>The SET program must:<br>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication<br>• Be conducted in a hospital outpatient setting or a physician's office<br>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD<br>• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques<br><br>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | |
| **Telemedicine**<br>Now you can see a doctor where and when it's convenient for you. The telemedicine benefit allows you to have an online video visit with a provider using a smartphone, tablet, or computer 24/7/365. No appointment necessary. Prescriptions can be prescribed when deemed medically appropriate.<br><br>Video visits are ideal for:<br>• Cough / sore throat<br>• Pink Eye<br>• Bronchitis<br>• Cold & Flu<br>• Allergies<br>• Headache<br>• Sinus infection<br>• Ear infection | There is no coinsurance, copayment, or deductible for the telemedicine visit. |

| Covered Service | What you pay |
|---|---|
| **Transportation Services**<br>To schedule transportation services, please contact Customer Service at 775-982-3112 or toll-free at 888-775-7003<br>Transportation Services benefit is limited to 24 one-way trips, OR **$1,250** total annual trip expenses, whichever occurs first. | **$0** copay per trip to a plan approved health related location.<br>**$1,250** copay annual trip expense maximum. |
| **Urgently needed services**<br>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.<br>Teladoc is Senior Care Plus' preferred Virtual Visit vendor. To access the platform, please navigate to the following website, https://member.teladoc.com/signin to register your account. You may also call Customer Service or Teladoc directly, 1-800-835-2362, for more information on how to use these services. No prior authorization required for Teladoc.<br>This coverage is available Nationwide with a $10,000 annual max. | **$25** copay for each Medicare-covered urgently needed care visit at a "preferred facility."<br>**$65** copay for each Medicare-covered urgently needed care visit at a "non-preferred" facility.<br>**$65** copay for Nationwide coverage of urgently needed services<br>**$0** copay for Virtual Urgent Care visits through Senior Care Plus's preferred Virtual Visit vendor, Teladoc. |
| **Vision care**<br>Covered services include:<br>• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.<br>• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of | **$45** copay for each Medicare-covered eye exam (diagnosis and treatment for disease and conditions of the eye).<br>**20%** coinsurance of the Medicare-approved amount for one pair of eyeglasses or one set of |

| Covered Service | What you pay |
|---|---|
| glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older.<br>• For people with diabetes, screening for diabetic retinopathy is covered once per year.<br>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.<br>• One (1) routine eye exam per year.<br>Allowance towards the purchase of a complete set of eyeglasses or contact lenses every 2 years. | contact lenses after each cataract surgery with an intraocular lens<br>**$0** copay for each yearly routine eye exam<br>Up to a **$170** copay allowance towards the purchase of a complete set of eyeglasses or contact lenses every year |
| **Welcome to Medicare preventive visit**<br>Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed.<br>**Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit. | There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. |
| **Wound Care**<br>Requires prior-authorization (approval in advance) to be covered to be covered over 12 visits per calendar year. All Biological Skin Therapies and Hyperbaric Therapy wound therapy requires prior-authorization to be covered. | **$0-$45** copay for each Medicare-covered wound therapy visit depending on place of service |

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

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

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

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

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

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

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Acupuncture** | Available for people with chronic low back pain under certain circumstances |
| **Cosmetic surgery or procedures** | Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member<br><br>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance |
| **Custodial care**<br><br>Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing | Not covered under any condition |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Experimental medical and surgical procedures, equipment, and medications**<br>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community | May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan<br>(Go to Chapter 3, Section 5 for more information on clinical research studies) |
| **Fees charged for care by your immediate relatives or members of your household** | Not covered under any condition |
| **Full-time nursing care in your home** | Not covered under any condition |
| **Home-delivered meals** | Not covered under any condition |
| **Homemaker services include basic household help, including light housekeeping or light meal preparation.** | Not covered under any condition |
| **Naturopath services (uses natural or alternative treatments)** | Not covered under any condition |
| **Non-routine dental care** | Dental care required to treat illness or injury may be covered as inpatient or outpatient care |
| **Orthopedic shoes or supportive devices for the feet** | Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease |
| **Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television** | Not covered under any condition |
| **Private room in a hospital** | Covered only when medically necessary. |
| **Reversal of sterilization procedures and or non-** | Not covered under any condition |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **prescription contraceptive supplies** | |
| **Routine chiropractic care** | Manual manipulation of the spine to correct a subluxation is covered |
| **Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids** | One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. |
| **Routine foot care** | Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes) |
| **Services considered not reasonable and necessary, according to Original Medicare standards** | Not covered under any condition |

# CHAPTER 5:
# Asking us to pay our share of a bill for covered medical services

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

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

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

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

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

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

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

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

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

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

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

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

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

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision.** If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've 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 *365 days*** of the date you got the service or item

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (www.seniorcareplus.com) or call Customer Service at (888) 775-7003 (TTY users call711) and ask for the form.

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

**Senior Care Plus**
10315 Professional Circle
Reno, NV 89521

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

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

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

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

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

# CHAPTER 6:
# Your rights and responsibilities

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

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

Debemos proporcionar la información de una manera que funciona para usted (en idiomas distintos del inglés, en braille, en grandes impresión u otros formatos, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at (888) 775-7003(TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Service (phone numbers are printed on the back cover of this booklet). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in our 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.

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 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've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Service at (888) 775-7003 (TTY users call 711) (phone numbers are printed on the back cover of this booklet).

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

As a member of *Senior Care Plus Patriot Plan*, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Service at (888) 775-7003 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **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.
    - For a list of the providers in the plan's network, see the *Provider Directory.*
    - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.SeniorCarePlus.com.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- If you have questions about the rules or restrictions, please contact Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

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

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

**How to set up an advance directive to give instructions:**

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from

organizations that give people information about Medicare. You can also call Customer Service at (888) 775-7003 (TTY users call 711 to ask for the forms.

- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

**If your instructions aren't followed**

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Board of Medical Examiners or the Nevada State Board of Osteopathic Medicine for MD's and DO's respectively:

| | |
|---|---|
| **Board of Medical Examiners**<br>1105 Terminal Way, Suite 301<br>Reno, Nevada 89502<br>775-688-2559<br>8:00 am to 5:00 pm<br>Monday through Friday | **Nevada State Board of Osteopathic Medicine**<br>2275 Corporate Circle, Suite 210<br>Henderson, NV 89074<br>877-325-7828<br>8:00 am to 5:00 pm<br>Monday through Friday |

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

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

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

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

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

- **Call Customer Service at (888) 775-7003 (TTY users call 711)**
- **Call your local SHIP** at 1-800-307-4444 or 1-877-385-2345
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

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

Get more information about your rights from these places:

- **Call Customer Service at (888) 775-7003 (TTY users call 711)**
- **Call your local SHIP** at 1-800-307-4444 or 1-877-385-2345
- **Contact Medicare**
    - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections.* (available at:)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

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

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at (888) 775-7003 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.

- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get 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 you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - You must continue to pay your premium for your Medicare Part B to stay a member of our plan.
    - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

**Right and Responsibilities**

**As a member, you have a right:**

**1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.**

**2. A right to be treated with respect and recognition of their dignity and their right to privacy.**

**3. A right to participate with practitioners in making decisions about their health care.**

**4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.**

**5. A right to voice complaints or appeals about the organization or the care it provides.**

**6. A right to make recommendations regarding the organization's member rights and responsibilities policy.**

**7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.**

**8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.**

**9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.**

**Our Philosophy of Care**

We represent a philosophy of health care that emphasizes active partnerships between members and their physicians. We believe members should have the right care, at the right time, in the right setting. We believe working with people to keep them healthy is as important as making them well.

We value prevention as a key component of comprehensive care - reducing the risks of illness and helping to treat small problems before they can become more severe. We are committed to high standards of quality, service and professional ethics and to the principle that members come first.

# CHAPTER 7:
# If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

### Section 1.1 Legal terms

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

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

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

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call customer service at (888) 775-7003 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

**State Health Insurance Assistance Program (SHIP)**

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can

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

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

**Medicare**

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit www.Medicare.gov

## SECTION 3 Which process to use for your problem

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

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

**Yes.**

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

**No.**

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

# Coverage decisions and appeals

## SECTION 4 A guide to coverage decisions and appeals

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

**Asking for coverage decisions before you get services**

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and

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

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

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

**Making an appeal**

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

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

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

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

- **Call Customer Service at (888) 775-7003 (TTY users call 711) (phone numbers are printed on the back cover of this booklet)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at (888) 775-7003 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Service at (888) 775-7003 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right

to ask the independent review organization to review our decision to dismiss your appeal.

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

### Section 4.2 Rules and deadlines for different situations

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

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 7**: 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, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure information applies to you, call Customer Service at (888) 775-7003 (TTY users call 711). You can also get help or information from your SHIP.

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

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

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

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

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

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3**

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

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

**Legal Terms:**

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

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

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

**A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:**

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

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

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

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

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

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

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

***For fast Coverage decisions, we use an expedited timeframe.***

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.

- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

## Section 5.3 How to make a Level 1 appeal

**Legal Terms:**

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

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

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

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

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

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

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

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

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

***Deadlines for a fast appeal***

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

***Deadlines for a standard appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)

- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.

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

### Section 5.4 The Level 2 appeal process

**Legal Term:**

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

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

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

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

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests.** For **expedited requests,** we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests,** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision or turning down your appeal.)** In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Tells you how to file a Level 3 appeal.

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

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

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

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

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

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

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

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

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

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.

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

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at (888) 775-7003 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

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

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**

   - You or someone who is acting on your behalf will be asked to sign the notice.

- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Customer Service at (888) 775-7003 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at (888) 775-7003 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document. SHIP contact information is available in Chapter 2, Section 3.

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

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

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

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at (888) 775-7003 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***If the independent review organization says yes:***

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

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

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

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

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

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

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

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

**Legal Term:**

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at (888) 775-7003 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document. SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

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

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

***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

**Legal Term:**

**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

***What happens during this review?***

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

**Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.**

***What happens if the reviewers say yes?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**

- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

***What happens if the reviewers say no?***

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

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

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

## Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

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

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

***What happens if the independent review organization says no?***

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

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

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

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

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

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

**Level 3 appeal**

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

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

- If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

**Level 4 appeal**

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

**Level 5 appeal**

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

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

# Making complaints

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

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

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

| Complaints | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you got (including care in the hospital)? |
| **Respecting your privacy** | • Did someone not respect your right to privacy or share confidential information? |
| **Disrespect, poor customer service, or other negative behaviors** | • Has someone been rude or disrespectful to you?<br>• Are you unhappy with our Customer Service?<br>• Do you feel you're being encouraged to leave our plan? |
| **Waiting times** | • Are you having trouble getting an appointment, or waiting too long to get it?<br>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan?<br>  o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription. |
| **Cleanliness** | • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office? |
| **Information you get from us** | • Did we fail to give you a required notice?<br>• Is our written information hard to understand? |

| Complaints | Example |
|---|---|
| **Timeliness**<br>(These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals) | If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:<br>• You asked us for a *fast coverage decision* or a *fast appeal,* and we said no; you can make a complaint.<br>• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.<br>• You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.<br>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint. |

## Section 9.2 How to make a complaint

**Legal Terms:**

A **complaint** is also called a **grievance.**

**Making a complaint** is called **filing a grievance.**

**Using the process for complaints** is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

**Step 1: Contact us promptly – either by phone or in writing.**

- **Calling Customer Service at (888) 775-7003 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know. Please contact Customer Service at 775-982-3112 or toll-free at 888-775-7003 (TTY only, call the State Relay Service at 711). (we are not open 7 days a week all year round) Hours are 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We

call this our Senior Care Plus grievance procedure. If you choose to call us or send us a letter about your complaint, follow these instructions:

  - To make a complaint, call Customer Service at the number on the cover of this booklet.
  - To make a complaint in writing, send a letter to: Senior Care Plus, 10315 Professional Circle, Reno, NV 89521.
  - For quality of care complaints, contact Commence Health, BFCC-QIO Program. (See Chapter 2, Section 4 on how to contact Commence Health.)

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

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

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

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

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

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

*Or*

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

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

You can submit a complaint about *Senior Care Plus Patriot Plan* directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

# CHAPTER 8:
# Ending membership in our plan

## SECTION 1 Ending your membership in our plan

Ending your membership in *Senior Care Plus Patriot Plan* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

### Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

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

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

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period**, you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of *Senior Care Plus Patriot Plan* 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. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.
    - Usually, when you move
    - If you have Medicaid
    - If we violate our contract with you
    - If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital

**Enrollment time periods vary** depending on your situation.

**To find out if you're eligible for a Special Enrollment Period**, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

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

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

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

- **Call Customer Service at (888) 775-7003 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

## SECTION 3 How to end your membership in our plan

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

| To switch from our plan to: | Here's what to do: |
|---|---|
| **Another Medicare health plan** | • Enroll in the new Medicare health plan.<br>• You'll automatically be disenrolled from *Senior Care Plus Patriot Plan* when your new plan's coverage starts. |
| **Original Medicare *with* a separate Medicare drug plan** | • Enroll in the new Medicare drug plan.<br>• You'll automatically be disenrolled from *Senior Care Plus Patriot Plan* when your new plan's coverage starts. |
| **Original Medicare *without* a separate Medicare drug plan** | • **Send us a written request to disenroll**. Call Customer Service at (888) 775-7003 (TTY users call 711) if you need more information on how to do this.<br>• You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.<br>• You'll be disenrolled from *Senior Care Plus Patriot Plan* when your coverage in Original Medicare starts. |

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

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

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

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

## SECTION 5 *Senior Care Plus Patriot Plan* must end our plan membership in certain situations

***Senior Care Plus Patriot Plan* must end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
    - If you move or take a long trip, call Customer Service at (888) 775-7003 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you let someone else use your membership card to get medical care (We can't make you leave our plan for this reason unless we get permission from Medicare first)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

If you have questions or want more information on when we can end your membership, call Customer Service at (888) 775-7003 (TTY users call 711).

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

*Senior Care Plus Patriot Plan* isn't allowed to ask you to leave our plan for any health-related reason.

**What should you do if this happens?**

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

### Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

# CHAPTER 9: Legal notices

## SECTION 1 Notice about governing law

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

## SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Customer Service at (888) 775-7003 (TTY users call 711). 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, *Senior Care Plus Patriot Plan*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in

subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

## SECTION 4 Notice about 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.**

If you have any questions about this notice, please contact Renown Health Corporate Compliance/Privacy office at 775-982-8300.

**AT A GLANCE**

| **Who can Hometown Health disclose your information to?** | |
|---|---|
| **Without your consent** | • Doctors, nurses, and others involved in treating you. This includes providers at other hospitals, clinics, and offices who have a treatment relationship with you.<br>• To insurance companies unless you pay for your visit in its entirety out of pocket up front and request your insurance not be billed.<br>• For healthcare operations such as quality reviews, safety and privacy investigations, or any other business need.<br>• As required by law. Nevada and Federal regulations require reporting of certain conditions, infections, illnesses, acts of violence, and other situations. |
| **Situations where you have the opportunity to object or opt-out** | • With your consent, our staff may discuss limited information with your family and friends about your condition or treatment. If you are unable to consent, staff will use professional judgment on whether the disclosure is in your best interest.<br>• Hometown Health may disclose information about you to the Renown Health Foundation for fundraising purposes. You may opt out of this by calling 775-982-8300 or by writing to the address below. |

**Who will follow this notice**

This notice describes the practices of Hometown Health. Hometown Health includes it employees, physician staff, trainees, volunteer groups, students, interns anyone authorized to enter information into your medical record, contracted employees, business associates and their employees, and other health care personnel. For the purposes of this notice, the entities, will be referred to in this notice as “Hometown Health.”

### Our pledge regarding medical information

We understand that medical information about you and your health is personal. We are committed to protecting your health information, including personal financial information related to your healthcare. We create a record of your benefits and eligibility status and claims history. We need this record to provide you with quality healthcare benefits and to comply with certain legal requirements. Hospitals, physicians and other healthcare providers providing healthcare services to Hometown Health members may have different policies or notices regarding their uses and disclosures of your medical information.

This notice will tell you how we use and disclose health information about you. We also tell you about your rights and obligations we have about the use of your medical information.

We are required by law to:

- Make sure your health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and,
- Follow the terms of the notice that is current in effect.

### How We May Use and Disclose Health Information about You

The following categories describe different ways that we use and disclose health information. For each category of use or disclosures, we will provide examples of the types of ways your information may be used. Not every use or disclosure in each category will be listed.

- **For Treatment.** We may use and disclose your health information during the provision, coordination, or management of healthcare and related services among healthcare providers, consultation between healthcare providers regarding your care, or the referral of care from one healthcare provider to another. For example, a clinician providing a vaccination to you may need to know if you are sick so that you do not receive a vaccine. The clinician may refer you to a doctor and may also need to tell the doctor that you are sick in order to arrange for appropriate medical services, to receive the vaccine at a later date.
- **For Payment.** We may use and disclose your health information in order to pay for your medical benefits under our health plan. These activities may include determining benefit eligibility, billing and collection activities, coordinating the payment for benefits with other health plans or third-parties, reviewing healthcare services for medical necessity, and performing utilization review. For example, to make payment for a healthcare claim, we may review medical information to make sure that the services provided to you were necessary.

- **For Healthcare Operations.** We may use and disclose your health information for health plan operations. These uses and disclosures are necessary to run the health plan and make sure that all of our members receive quality benefits and customer service. For example:
    - We may use and disclose general health information but not reveal your identity in the publication of newsletters that offer members information on various healthcare issues such as asthma, diabetes, and breast cancer.
    - We may use and disclose your health information for claims management, utilization review and management, data and information systems management, medical necessity review, coordination of care, benefits and services, responding to member inquiries or requests for services, processing of grievances, appeals and external reviews, benefits and program analysis and reporting, risk management, detection and investigation of fraud and other unlawful conduct, auditing, underwriting, and ratemaking.
    - We may use and disclose your health information for the operation of disease and case management programs, through which we or our contractors perform risk and health assessments, identify and contact members who may benefit from participation in disease or case management programs, and send relevant information to those members who enroll in the programs and their providers.
    - We may use and disclose your health information for quality assessment and improvement activities, such as peer review and credentialing of participating providers, program development, and accreditation by independent organizations.
    - We may use and disclose your health information to the sponsor of the plan if we are providing health benefits to you as a beneficiary of an employer-sponsored group health plan.
    - We may use and disclose your health information for the transition of policies or contracts from and to other health plans.
- **To Your Family and Friends.** We may use and disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare. Before we disclose your medical information to a person involved in your healthcare or payment for your healthcare, we will provide you with an opportunity to object to such uses and disclosures. If you are not present, or in the event of your incapacity or an emergency, we will use and disclose your health information based on our professional judgment of whether the use or disclosure would be in your best interest.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. We must also share your medical information with authorities that monitor our compliance with privacy laws.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

**Special Situations**

- **Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military command authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Public Health Risks.** As required by law, we may disclose health information about you for public health activities. These activities may include the following:
    - To prevent or control disease, injury, or disability;
    - To report birth and deaths;
    - To report the abuse or neglect of children, elders, and dependent adults;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make the disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement.** We may disclose health information if asked to do so by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons, or similar process;

  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the hospital; or
  - In emergency circumstances to report a crime; the location of the crime victims; or the identity, description, or location of the person who committed the crime.

- **Nevada Attorney General and Grand Jury Investigations.** We may disclose health information if asked to do so by an investigator for the Nevada Attorney General, or a grand jury, investigating an alleged violation of Nevada laws prohibiting patient neglect, elder abuse, or submission of false claims to the Medicaid program. We may also disclose health information to an investigator for the Nevada Attorney General investigating an alleged violation of Nevada workers' compensation laws.
- **National Security.** We may disclose health information about you to authorized federal officials for purposes of national security.
- **Inmates.** An inmate does not have the right to this notice. If you are an inmate of a correctional facility or are under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary to provide you with health care or to protect your health and safety or health and safety of others, including the correctional institution.

**Former Members of Hometown Health**

Hometown Health does not destroy the health information of individuals who terminate their coverage with us. The information is necessary and is used for many purposes described above, even after an individual leaves a plan, and in many cases is subject to legal retention requirements. The procedures that protect that information against inappropriate use or disclosure apply regardless of the status of any individual member.

**Your Rights Regarding Health Information About You**

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about your benefits. Usually, this includes benefits, eligibility and claims records, but may not include some mental health information.
  To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing. We may charge you a fee for the cost of

copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in very limited circumstances. You may request that a denial be reviewed.

- **Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Hometown Health. To request an amendment to your record, you must send a written request providing a reason that supports your request.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the records used to make decisions about you;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to receive a list of disclosures we made with your health information. This list will not include all disclosures made. This list will not include disclosures made for treatment, payment, or health care operations, disclosures made more than six years prior, or disclosures you specifically authorized. To request this list or an “accounting of disclosures” you must submit your request in writing.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you to someone who is involved in your care or in the payment for your care, such as a family member or friend. We are not required to agree with your request, unless the request seeks a restriction on the disclosure of information to a health plan, the disclosure is for the purpose of carrying out payment or health care operations, and is not otherwise required by law, and the information relates to an item or service which you, or someone acting for you other than the health plan, has paid us in full. If we do agree with your restriction, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing.
  Your request must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (For example, disclosures to your spouse)
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain

locations. For example, you can ask that we only contact you by mail or at work. We will accommodate all reasonable requests. You must make your request in writing.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a current copy of this notice at www.HometownHealth.com.
- To make a request for: inspection of your health record, amendment to your health record, accounting of disclosures, restrictions on information we may release, or confidential communications, please submit your request in writing to:

  Hometown Health Compliance Officer
  10315 Professional Circle Mail Stop T-9
  Reno, NV 89521

**Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective immediately for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities and at www.HometownHealth.com. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you enroll in a Hometown Health plan, we will offer you a copy of the current notice in effect.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us by contacting 775-982-8300. You may also file a complaint with the Office for Civil Rights at www.hhs.gov/ocr or you may file a complaint in writing to:

Renown Health Chief Compliance Officer
1155 Mill St, Mail Stop N-14
Reno, NV 89502

**You will not be penalized for filing a complaint.**

**Other Uses of Medical Information**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you by signing an authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have

already made with your permission, and that we are required to retain our records of the care that we provided to you.

**Notice to Patients Regarding the Destruction of Health Care Records**

In accordance with NRS 629.051, your regularly maintained health records will be retained for five years after receipt or production, unless otherwise provided for by federal law. If you are less than 23 years old on the date of destruction your records will not be destroyed; after you have reached 23 years of age, your records will be destroyed after a five year retention, unless otherwise provided by federal law. In accordance with 42 CFR 422.504(d) and (e); 423.505(d) and (e), Hometown Health as a Medicare Advantage organization, will retain health records for Medicare Advantage beneficiaries for 10 years, unless otherwise provided for by federal law.

## SECTION 5 Notice about Assignment

The benefits provided under this Evidence of Coverage are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

## SECTION 6 Notice about Entire Contract

This Evidence of Coverage and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

## SECTION 7 Notice about Waiver by Agents

No agent or other person, except an executive officer of your plan, has authority to waive any conditions or restrictions of this Evidence of Coverage or the medical benefit chart located in the front of this booklet. No change in this Evidence of Coverage shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by an authorized company officer.

## SECTION 8 Notice about Plan’s Sole Discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the Evidence of Coverage. This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

## SECTION 9 Notice about Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Hometown Health Customer Service (the phone number and hours of availability are located in the back of this booklet). The plan will send this information to you within 30 days of your request.

## SECTION 10 Notice about Information on Advance Directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your healthcare in case you become unable to make your own health care decisions). You have the right to make your own health care decisions. But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would want and not want if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives. It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance? If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 2 of this booklet tells how to contact your SHIP. (SHIPs have different names depending on which state you are in.)

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. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you. If you are hospitalized, they will ask you about an advance directive. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one. It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, refer to Chapter 8, Section 1.6, subsection *"What if your instructions are not followed?*

## SECTION 11 Notice about Continuity and Coordination of Care

Your plan has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, your plan helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

## SECTION 12 Notice about Medicare Secondary Payer subrogation rights

**Discrimination is against the law.**

Senior Care Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Senior Care Plus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Senior Care Plus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Compliance Officer.

If you believe that Senior Care Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Officer, 10315 Professional Circle, Reno, NV, 89521, 800-611-5097, (TTY: 1- 800-833-5833). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

# CHAPTER 10: Definitions

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

**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 payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

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

**Benefit Period** –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

**Chronic-Care Special Needs Plan (C-SNP)** – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

**Complaint** – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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

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

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

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

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

**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 people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

**Dually Eligible Individual** – A person who is eligible for Medicare and Medicaid coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

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

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

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

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

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

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

**Initial Enrollment Period –** When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn

65, your Initial Enrollment Period is the 7-month period that begins 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)** – Go to Extra Help.

**Maximum Out-of-Pocket Amount –** The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for our plan premiums and Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount.

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

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

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

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

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. *Senior Care Plus Patriot Plan* doesn't offer Medicare prescription drug coverage.

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

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

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

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

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

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

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

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

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

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

**Original Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by

Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

**Out-of-Pocket Costs** – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

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

**Part C –** Go to 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're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

**Preventive services** – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

**Primary Care Physician (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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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

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

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

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

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

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

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

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

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

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

medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

**Senior Care Plus Patriot Plan Customer Service**

| Method | Member Services – Contact Information |
|---|---|
| **Call** | 775-982-3112 or toll-free at 888-775-7003<br><br>Calls to this number are free.<br>(We are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday<br><br>Customer Service (888) 775-7003 (TTY users call 711) also has free language interpreter services available for non-English speakers. |
| **TTY** | State Relay Service - 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br><br>Calls to this number are free.<br>(We are not open 7 days a week all year round) Hours are 7:00 a.m. to 8:00 p.m., Monday to Friday (except holidays) from April 1 through September 30. Hours are 7:00 a.m. to 8:00 p.m. October 1 through March 31, and Monday to Friday (except Thanksgiving and Christmas) and 8:00 a.m. to 8:00 p.m. Saturday-Sunday |
| **Fax** | ***775-982-3741*** |
| **Write** | Senior Care Plus<br>10315 Professional Circle<br>Reno, NV 89521<br>E-mail: Customer_Service@hometownhealth.com |
| **Website** | www.seniorcareplus.com |

***Nevada SHIP***

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

| Method | Member Services – Contact Information |
|---|---|
| **Call** | 1-800-307-4444 or 1-877-385-2345 |
| **TTY** | 1-877-486-2048 (Medicare)<br><br>This number requires special telephone equipment and is only for people who have difficulty hearing or speaking. |

| Method | Member Services – Contact Information |
|---|---|
| **Write** | State of Nevada Aging and Disability Services Division<br>3416 Goni Road, Suite D-132<br>Carson City, NV 89706 |
| **Website** | http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/ or<br>www.accesstohealthcare.org |

***PRA Disclosure Statement*** *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

# 2026 Senior Care Plus Comprehensive Dental Benefits
# Select Plan and Patriot Plan

| $1,500 CALENDAR YEAR MAXIMUM - Comprehensive Services Only | | | | |
|---|---|---|---|---|
| The following is a complete list of dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. Members must utilize an in network provider to receive benefits. **If elected, Member is responsible for all non-covered procedures.** | | | | |
| **CDT Code** | **Description** | **Member Responsibility** | **Limitations** | **Documentation/X-Rays Required** |
| | **Diagnostic Services** | | | |
| D0120 | Periodic oral evaluation | 0% | 1 of (D0120-D0180) every calendar year | |
| D0140 | Limited oral evaluation | 0% | | |
| D0150 | Comprehensive oral evaluation | 0% | | |
| D0160 | Oral evaluation, problem focused | 0% | | |
| D0170 | Re-evaluation, limited, problem focused | 0% | | |
| D0171 | Re-evaluation, post operative office visit | 0% | | |
| D0180 | Comprehensive periodontal evaluation | 0% | | |
| D0210 | Intraoral, comprehensive series of radiographic images | 0% | 1 of (D0210, D0330) every 3 calendar years | |
| D0220 | Intraoral, periapical, first radiographic image | 0% | | |
| D0230 | Intraoral, periapical, each add 'l radiographic image | 0% | | |
| D0240 | Intraoral, occlusal radiographic image | 0% | 1 (D0240) every calendar year | |
| D0270 | Bitewing, single radiographic image | 0% | 1 of (D0270-D0274) every calendar year | |
| D0272 | Bitewings, two radiographic images | 0% | | |
| D0273 | Bitewings, three radiographic images | 0% | | |
| D0274 | Bitewings, four radiographic images | 0% | | |
| D0277 | Vertical bitewings, 7 to 8 radiographic images | 0% | 1 (D0277) every 3 calendar years | |
| D0330 | Panoramic radiographic image | 0% | 1 of (D0210, D0330) every 3 calendar years | |
| | **Preventive Services** | | | |
| D1110 | Prophylaxis, adult | 0% | 2 of (D1110, D4346, D4910) every calendar year | |
| **Calendar Year Maximum: $1,500 Applies to All Comprehensive Services Below (Diagnostic Services and Preventive Services Waived)** | | | | |
| | **Restorative Services** | | | |
| D2140 | Amalgam, one surface, primary or permanent | 0% | 1 of (D2140-D2335, D2391-D2394) per surface per tooth every 3 calendar years | |
| D2150 | Amalgam, two surfaces, primary or permanent | 0% | | |
| D2160 | Amalgam, three surfaces, primary or permanent | 0% | | |
| D2161 | Amalgam, four or more surfaces, primary or permanent | 0% | | |
| D2330 | Resin-based composite, one surface, anterior | 0% | | |
| D2331 | Resin-based composite, two surfaces, anterior | 0% | | |
| D2332 | Resin-based composite, three surfaces, anterior | 0% | | |
| D2335 | Resin-based composite, four or more surfaces | 0% | | |
| D2391 | Resin-based composite, one surface, posterior | 0% | | |
| D2392 | Resin-based composite, two surfaces, posterior | 0% | | |
| D2393 | Resin-based composite, three surfaces, posterior | 0% | | |
| D2394 | Resin-based composite, four or more surfaces, posterior | 0% | | |
| D2510 | Inlay, metallic, one surface | 0% | 1 of (D2510-D2792) per tooth every 5 calendar years | Pre-operative bitewing and periapical x-ray, bitewing of crown delivery, narrative and/or intra-oral photo, required with claim submission. |
| D2520 | Inlay, metallic, two surfaces | 0% | | |
| D2530 | Inlay, metallic, three or more surfaces | 0% | | |
| D2542 | Onlay, metallic, two surfaces | 0% | | |
| D2543 | Onlay, metallic, three surfaces | 0% | | |
| D2544 | Onlay, metallic, four or more surfaces | 0% | | |
| D2610 | Inlay, porcelain/ceramic, one surface | 0% | | |
| D2620 | Inlay, porcelain/ceramic, two surfaces | 0% | | |
| D2630 | Inlay, porcelain/ceramic, three or more surfaces | 0% | | |
| D2642 | Onlay, porcelain/ceramic, two surfaces | 0% | | |
| D2643 | Onlay, porcelain/ceramic, three surfaces | 0% | | |
| D2644 | Onlay, porcelain/ceramic, four or more surfaces | 0% | | |
| D2650 | Inlay, resin-based composite, one surface | 0% | | |
| D2651 | Inlay, resin-based composite, two surfaces | 0% | | |
| D2652 | Inlay, resin-based composite, three or more surfaces | 0% | | |
| D2662 | Onlay, resin-based composite, two surfaces | 0% | | |
| D2663 | Onlay, resin-based composite, three surfaces | 0% | | |
| D2664 | Onlay, resin-based composite, four or more surfaces | 0% | | |
| D2710 | Crown, resin-based composite (indirect) | 0% | | |

# Senior Care Plus Comprehensive

| CDT Code | Description | Member Responsibility | Limitations | Documentation/X-Rays Required |
|---|---|---|---|---|
| | **Restorative Services (continued)** | | | |
| D2712 | Crown, ¾ resin-based composite (indirect) | 0% | 1 of (D2510-D2792) per tooth every 5 calendar years | Pre-operative bitewing and periapical x-ray, bitewing of crown delivery, narrative and/or intra-oral photo, required with claim submission. |
| D2721 | Crown, resin with predominantly base metal | 0% | | |
| D2722 | Crown, resin with noble metal | 0% | | |
| D2740 | Crown, porcelain/ceramic | 0% | | |
| D2750 | Crown, porcelain fused to high noble metal | 0% | | |
| D2751 | Crown, porcelain fused to predominantly base metal | 0% | | |
| D2752 | Crown, porcelain fused to noble metal | 0% | | |
| D2781 | Crown, ¾ cast predominantly base metal | 0% | | |
| D2782 | Crown, ¾ cast noble metal | 0% | | |
| D2783 | Crown, ¾ porcelain/ceramic | 0% | | |
| D2791 | Crown, full cast predominantly base metal | 0% | | |
| D2792 | Crown, full cast noble metal | 0% | | |
| D2910 | Re-cement or re-bond inlay, onlay, veneer, or partial coverage | 0% | 1 of (D2910, D2920) per tooth every calendar year | |
| D2920 | Re-cement or re-bond crown | 0% | | |
| D2915 | Re-cement or re-bond indirectly fabricated/prefabricated post & core | 0% | 1 (D2915) per tooth every calendar year | |
| D2940 | Placement of interim direct restoration | 0% | | |
| D2950 | Core buildup, including any pins when required | 0% | | Pre-operative bitewing and periapical x-ray required with claim submission |
| D2951 | Pin retention, per tooth, in addition to restoration | 0% | | |
| D2952 | Post and core in addition to crown, indirectly fabricated | 0% | | |
| D2953 | Each additional indirectly fabricated post, same tooth | 0% | | |
| D2954 | Prefabricated post and core in addition to crown | 0% | | |
| D2955 | Post removal | 0% | | |
| | **Endodontic Services** | | | |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | 0% | 1 of (D3310-D3330) per tooth in a lifetime | |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | 0% | | |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | 0% | | |
| D3331 | Treatment of root canal obstruction; non-surgical access | 0% | 1 (D3331) per tooth in a lifetime | |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth | 0% | 1 (D3332) per tooth in a lifetime | |
| D3333 | Internal root repair of perforation defects | 0% | 1 (D3333) per tooth in a lifetime | |
| D3346 | Retreatment of previous root canal therapy, anterior | 0% | 1 of (D3346-D3348) per tooth in a lifetime | |
| D3347 | Retreatment of previous root canal therapy, premolar | 0% | | |
| D3348 | Retreatment of previous root canal therapy, molar | 0% | | |
| D3351 | Apexification/recalcification, initial visit | 0% | 1 (D3351) per tooth in a lifetime | |
| D3352 | Apexification/recalcification, interim medication replacement | 0% | 1 (D3352) per tooth in a lifetime | |
| D3353 | Apexification/recalcification, final visit | 0% | 1 (D3353) per tooth in a lifetime | |
| D3410 | Apicoectomy, anterior | 0% | 1 of (D3410-D3425) per tooth in a lifetime | |
| D3421 | Apicoectomy, premolar (first root) | 0% | | |
| D3425 | Apicoectomy, molar (first root) | 0% | | |
| D3426 | Apicoectomy, (each additional root) | 0% | 1 (D3426) per tooth in a lifetime | |
| D3430 | Retrograde filling, per root | 0% | 1 (D3430) per tooth in a lifetime | |
| D3450 | Root amputation, per root | 0% | 1 (D3450) per tooth in a lifetime | |
| D3920 | Hemisection, not including root canal therapy | 0% | 1 (D3920) per tooth in a lifetime | |
| | **Periodontal Services** | | | |
| D4210 | Gingivectomy or gingivoplasty, four or more teeth per quadrant | 0% | 1 of (D4210, D4211) per site/quad every 2 calendar years | |
| D4211 | Gingivectomy or gingivoplasty, one to three teeth per quadrant | 0% | | |
| D4240 | Gingival flap procedure, four or more teeth per quadrant | 0% | | |
| D4241 | Gingival flap procedure, one to three teeth per quadrant | 0% | | |
| D4260 | Osseous surgery, four or more teeth per quadrant | 0% | 1 of (D4260, D4261) per site/quad every 2 calendar years | |
| D4261 | Osseous surgery, one to three teeth per quadrant | 0% | | |
| D4270 | Pedicle soft tissue graft procedure | 0% | 1 of (D4270-D4285) per site/quad every 2 calendar years | |
| D4273 | Autogenous connective tissue graft procedure, first tooth | 0% | | |
| D4275 | Non-autogenous connective tissue graft, first tooth | 0% | | |
| D4283 | Autogenous connective tissue graft procedure, each additional tooth, per site | 0% | | |
| D4285 | Non-autogenous connective tissue graft procedure, each additional tooth, per site | 0% | | |
| D4341 | Periodontal scaling and root planing, four or more teeth per quadrant | 0% | 1 of (D4341, D4342) per site/quad every 2 calendar years | Full mouth x-rays and periodontal chart required with claim submission |
| D4342 | Periodontal scaling and root planing, one to three teeth per quadrant | 0% | | |

# Senior Care Plus Comprehensive

| CDT Code | Description | Member Responsibility | Limitations | Documentation/X-Rays Required |
|---|---|---|---|---|
| | **Periodontal Services (continued)** | | | |
| D4346 | Scaling in presence of moderate or severe inflammation, full mouth after evaluation | 0% | 2 of (D1110, D4346, D4910) every calendar year | |
| D4355 | Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit | 0% | 1 (D4355) every 3 calendar years | |
| D4910 | Periodontal maintenance | 0% | 2 of (D1110, D4346, D4910) every calendar year | |
| | **Removable Prosthodontic Services** | | | |
| D5110 | Complete denture, maxillary | 0% | 1 of (D5110-D5226, D5282, D5283, D5863-D5866) per arch every 5 calendar years | |
| D5120 | Complete denture, mandibular | 0% | | |
| D5130 | Immediate denture, maxillary | 0% | | |
| D5140 | Immediate denture, mandibular | 0% | | |
| D5211 | Maxillary partial denture, resin base | 0% | | |
| D5212 | Mandibular partial denture, resin base | 0% | | |
| D5213 | Maxillary partial denture, cast metal, resin base | 0% | | |
| D5214 | Mandibular partial denture, cast metal, resin base | 0% | | |
| D5221 | Immediate maxillary partial denture, resin base | 0% | | |
| D5222 | Immediate mandibular partial denture, resin base | 0% | | |
| D5223 | Immediate maxillary partial denture, cast metal framework, resin denture base | 0% | | |
| D5224 | Immediate mandibular partial denture, cast metal framework, resin denture base | 0% | | |
| D5225 | Maxillary partial denture, flexible base | 0% | | |
| D5226 | Mandibular partial denture, flexible base | 0% | | |
| D5282 | Removable unilateral partial denture, one piece cast metal, maxillary | 0% | | |
| D5283 | Removable unilateral partial denture, one piece cast metal, mandibular | 0% | | |
| D5410 | Adjust complete denture, maxillary | 0% | 1 of (D5410-D5422) per arch every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5411 | Adjust complete denture, mandibular | 0% | | |
| D5421 | Adjust partial denture, maxillary | 0% | | |
| D5422 | Adjust partial denture, mandibular | 0% | | |
| D5511 | Repair broken complete denture base, mandibular | 0% | 1 of (D5511, D5512) per arch every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5512 | Repair broken complete denture base, maxillary | 0% | | |
| D5520 | Replace missing or broken teeth, complete denture, per tooth | 0% | 1 (D5520) per arch every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5611 | Repair resin partial denture base, mandibular | 0% | 1 of (D5611-D5622) per arch every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5612 | Repair resin partial denture base, maxillary | 0% | | |
| D5621 | Repair cast partial framework, mandibular | 0% | | |
| D5622 | Repair cast partial framework, maxillary | 0% | | |
| D5630 | Repair or replace broken retentive clasping materials, per tooth | 0% | 1 (D5630) per tooth every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5640 | Replace missing or broken teeth, partial denture, per tooth | 0% | 1 (D5640) per tooth every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5650 | Add tooth to existing partial denture, per tooth | 0% | 1 (D5650) per tooth every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5660 | Add clasp to existing partial denture, per tooth | 0% | 1 (D5660) per tooth every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5670 | Replace all teeth & acrylic on cast metal frame, maxillary | 0% | 1 of (D5670, D5671) per arch every 2 calendar years; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5671 | Replace all teeth & acrylic on cast metal frame, mandibular | 0% | | |
| D5710 | Rebase complete maxillary denture | 0% | 1 of (D5710-D5761) per arch every 2 calendar years; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5711 | Rebase complete mandibular denture | 0% | | |
| D5720 | Rebase maxillary partial denture | 0% | | |
| D5721 | Rebase mandibular partial denture | 0% | | |
| D5730 | Reline complete maxillary denture, direct | 0% | | |
| D5731 | Reline complete mandibular denture, direct | 0% | | |
| D5740 | Reline maxillary partial denture, direct | 0% | | |
| D5741 | Reline mandibular partial denture, direct | 0% | | |
| D5750 | Reline complete maxillary denture, indirect | 0% | | |
| D5751 | Reline complete mandibular denture, indirect | 0% | | |
| D5760 | Reline maxillary partial denture, indirect | 0% | | |
| D5761 | Reline mandibular partial denture, indirect | 0% | | |

# Senior Care Plus Comprehensive

| CDT Code | Description | Member Responsibility | Limitations | Documentation/X-Rays Required |
|---|---|---|---|---|
| | **Removable Prosthodontic Services (continued)** | | | |
| D5810 | Interim complete denture, maxillary | 0% | 1 of (D5810-D5821) per arch every 5 calendar years | |
| D5811 | Interim complete denture, mandibular | 0% | | |
| D5820 | Interim partial denture, maxillary | 0% | | |
| D5821 | Interim partial denture, mandibular | 0% | | |
| D5850 | Tissue conditioning, maxillary | 0% | 1 of (D5850, D5851) per arch every calendar year; not payable within 6 months of initial appliance performed by same provider/location. | |
| D5851 | Tissue conditioning, mandibular | 0% | | |
| D5863 | Overdenture, complete, maxillary | 0% | 1 of (D5110-D5226, D5282, D5283, D5863-D5866) per arch every 5 calendar years | |
| D5864 | Overdenture, partial, maxillary | 0% | | |
| D5865 | Overdenture, complete, mandibular | 0% | | |
| D5866 | Overdenture, partial, mandibular | 0% | | |
| | **Oral & Maxillofacial Services** | | | |
| D7140 | Extraction, erupted tooth or exposed root | 0% | | |
| D7210 | Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth | 0% | | Pre-operative periapical x-ray and narrative required with claim submission. |
| D7220 | Removal of impacted tooth, soft tissue | 0% | | |
| D7230 | Removal of impacted tooth, partially bony | 0% | | |
| D7240 | Removal of impacted tooth, completely bony | 0% | | |
| D7241 | Removal impacted tooth, complete bony, complication | 0% | | |
| D7250 | Removal of residual tooth roots (cutting procedure) | 0% | | |
| D7260 | Oroantral fistula closure | 0% | 1 of (D7260, D7261) site/quad every 5 calendar years | |
| D7261 | Primary closure of a sinus perforation | 0% | | |
| D7270 | Tooth reimplantation and/or stabilization, accident | 0% | 1 of (D7270, D7272) per tooth every 5 calendar years | |
| D7272 | Tooth transplantation | 0% | | |
| D7280 | Exposure of an unerupted tooth | 0% | 1 (D7280) per tooth every 5 calendar years | |
| D7282 | Mobilization of erupted/malpositioned tooth | 0% | 1 of (D7282, D7283) per tooth every 5 calendar years | |
| D7283 | Placement, device to facilitate eruption, impaction | 0% | | |
| D7285 | Incisional biopsy of oral tissue, hard (bone, tooth) | 0% | 1 of (D7285-D7288) per site every 5 calendar years | |
| D7286 | Incisional biopsy of oral tissue, soft | 0% | | |
| D7287 | Exfoliative cytological sample collection | 0% | | |
| D7288 | Brush biopsy, transepithelial sample collection | 0% | | |
| D7290 | Surgical repositioning of teeth | 0% | 1 (D7290) per site/quad every 5 calendar years | |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | 0% | 1 (D7291) per site/quad every 5 calendar years | |
| D7292 | Placement of temporary anchorage device [screw retained plate] requiring flap | 0% | 1 of (D7292-D7294) per site/quad every 5 calendar years | |
| D7293 | Placement of temporary anchorage device requiring flap | 0% | | |
| D7294 | Placement of temporary anchorage device without flap | 0% | | |
| D7298 | Removal of temporary anchorage device [screw retained plate], requiring flap | 0% | 1 of (D7298-D7300) per site/quad every 5 calendar years | |
| D7299 | Removal of temporary anchorage device, requiring flap | 0% | | |
| D7300 | Removal of temporary anchorage device without flap | 0% | | |
| D7310 | Alveoloplasty with extractions, four or more teeth per quadrant | 0% | 1 of (D7310-D7321) per site/quad every 5 calendar years | |
| D7311 | Alveoloplasty with extractions, one to three teeth per quadrant | 0% | | |
| D7320 | Alveoloplasty, w/o extractions, four or more teeth per quadrant | 0% | | |
| D7321 | Alveoloplasty, w/o extractions, one to three teeth per quadrant | 0% | | |
| D7340 | Vestibuloplasty, ridge extension (2nd epithelialization) | 0% | 1 (D7340) per arch every 5 calendar years | |
| D7350 | Vestibuloplasty, ridge extension | 0% | 1 (D7350) per arch every 5 calendar years | |
| D7410 | Excision of benign lesion, up to 1.25 cm | 0% | | |
| D7411 | Excision of benign lesion, greater than 1.25 cm | 0% | | |
| D7412 | Excision of benign lesion, complicated | 0% | | |
| D7413 | Excision of malignant lesion, up to 1.25 cm | 0% | | |
| D7414 | Excision of malignant lesion, greater than 1.25 cm | 0% | | |
| D7415 | Excision of malignant lesion, complicated | 0% | | |
| D7440 | Excision of malignant tumor, up to 1.25 cm | 0% | | |
| D7441 | Excision of malignant tumor, greater than 1.25 cm | 0% | | |
| D7450 | Removal, benign odontogenic cyst/tumor, up to 1.25 cm | 0% | | |
| D7451 | Removal, benign odontogenic cyst/tumor, greater than 1.25 cm | 0% | | |
| D7460 | Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm | 0% | | |
| D7461 | Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm | 0% | | |
| D7465 | Destruction of lesion(s) by physical or chemical method, by report | 0% | | |

# Senior Care Plus Comprehensive

| CDT Code | Description | Member Responsibility | Limitations | Documentation/X-Rays Required |
|---|---|---|---|---|
| | **Oral & Maxillofacial Services (continued)** | | | |
| D7471 | Removal of lateral exostosis, maxilla or mandible | 0% | 1 of (D7471-D7473) in a lifetime | |
| D7472 | Removal of torus palatinus | 0% | | |
| D7473 | Removal of torus mandibularis | 0% | | |
| D7485 | Reduction of osseous tuberosity | 0% | 1 (D7485) in a lifetime | |
| D7490 | Radical resection of maxilla or mandible | 0% | 1 (D7490) per arch in a lifetime | |
| D7510 | Incision & drainage of abscess, intraoral soft tissue | 0% | | |
| D7511 | Incision & drainage of abscess, intraoral soft tissue, complicated | 0% | | |
| D7520 | Incision & drainage of abscess, extraoral soft tissue | 0% | | |
| D7521 | Incision & drainage of abscess, extraoral soft tissue, complicated | 0% | | |
| D7530 | Remove foreign body, mucosa, skin, tissue | 0% | | |
| D7540 | Removal of reaction producing foreign bodies, musculoskeletal system | 0% | | |
| D7961 | Buccal/labial frenectomy (frenulectomy) | 0% | 1 (D7961) per arch every 5 calendar years | |
| D7962 | Lingual frenectomy (frenulectomy) | 0% | 1 (D7962) every 5 calendar years | |
| D7963 | Frenuloplasty | 0% | 1 (D7963) every 5 calendar years | |
| | **Adjunctive General Services** | | | |
| D9110 | Palliative treatment of dental pain, per visit | 0% | 1 (D9110) every calendar year | |
| D9120 | Fixed partial denture sectioning | 0% | 1 (D9120) every calendar year | |
| D9210 | Local anesthesia not in conjunction, operative or surgical procedures | 0% | | |
| D9211 | Regional block anesthesia | 0% | | |
| D9212 | Trigeminal division block anesthesia | 0% | | |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | 0% | | |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia | 0% | | |
| D9222 | Deep sedation/general anesthesia, first 15 minute increment | 0% | Covered when performed in conjunction with complex oral surgery or with documented medical conditions. Patient apprehension and/or nervousness is not sufficient justification for deep sedation/general anesthesia or IV sedation. Not payable with other sedation services on same date of service. | |
| D9223 | Deep sedation/general anesthesia, each subsequent 15 minute increment | 0% | | |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | 0% | Not payable with general anesthesia, IV sedation or non-IV sedation. | |
| D9239 | Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment | 0% | Covered when performed in conjunction with complex oral surgery or with documented medical conditions. Patient apprehension and/or nervousness is not sufficient justification for deep sedation/general anesthesia or IV sedation. Not payable with other sedation services on same date of service. | |
| D9243 | Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment | 0% | | |
| D9248 | Non-intravenous (conscious) sedation, includes non-IV minimal and moderate sedation | 0% | Not payable with general anesthesia, IV sedation or nitrous. | |
| D9310 | Consultation, other than requesting dentist | 0% | 2 (D9310) every calendar year | |
| D9995 | Teledentistry, synchronous; real-time encounter | 0% | 2 of (D9995, D9996) every calendar year | |
| D9996 | Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review | 0% | | |

# NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

English – ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-775-7003 (TTY: 711) or speak to your provider.

Spanish / Español – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-775-7003 (TTY: 711) o hable con su proveedor.

Traditional Chinese / 台語 – 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-888-775-7003 (TTY: 711) 或與您的提供者討論。

Simplified Chinese / 中文 – 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-775-7003 (TTY: 711) 或咨询您的服务提供商。

Tagalog / Tagalog – PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-775-7003 o makipag-usap sa iyong provider.

French / Français – ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-775-7003 (TTY: 711) ou parlez à votre fournisseur.

Vietnamese / Việt – LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-775-7003 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

German / Deutsch – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-775-7003 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

**Korean** / 한국어 – 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-775-7003 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Russian** / РУССКИЙ – ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-775-7003 (TTY: 711) или обратитесь к своему поставщику услуг.

**Arabic** / العربية –
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-888-775-7003 (TTY: 711) أو تحدث إلى مقدم الخدمة".

**Hindi** / हिंदी – ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-888-775-7003 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

**Italian** / Italiano – ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-888-775-7003 (TTY: 711) o parla con il tuo fornitore.

**Brazilian Portuguese** / Português do Brasil – ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-888-775-7003 (TTY: 711) ou fale com seu provedor.

**Polish** / POLSKI – UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-888-775-7003 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

**Japanese** / 日本語 – 注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-888-775-7003 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。