

Horizon Medicare Advantage NJ DIRECT15 (PPO)



2018 Annual Notice of Change & Evidence of Coverage

Important information about changes to your Medicare health plan.



HorizonBlue.com/shbp

Product: **Horizon Medicare Advantage NJ DIRECT15 (PPO)**

Group Name: **State Health Benefits Program - Local Government**

Group Number: **095552-015**

This document also includes your Annual Notice of Change (ANOC)



Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark NJ 07105-2200
www.horizonblue.com

December 29, 2017

Re: State Health Benefits Program- Local Government

Group Contract No. 095552-015

Dear Member:

Thank you for being a Member of our Plan. Enclosed is the copy of the Evidence of Coverage (EOC) and your Annual Notice of Change (ANOC). This Policy reflects your Horizon Medicare Advantage NJ DIRECT15 (PPO) coverage effective **January 1, 2018**. A Policy has been fully executed on behalf of Horizon Insurance Company.

We value your membership and will strive to have a long time relationship with you. If you have any questions or need additional information, please contact Member Services at **1-800-414-7427**.

Horizon Medicare Advantage NJ DIRECT15 (PPO) offered by Horizon Insurance Company (Horizon)

Annual Notice of Changes for 2018

Dear Member:

We, at Horizon Insurance Company (Horizon), want to thank you for your membership and inform you of some new changes to your current Horizon Medicare Advantage NJ DIRECT15 (PPO) coverage beginning **January 1, 2018**.

Next year, there will be some changes to the plan's benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - It's important to review your coverage now to make sure it will meet your needs next year.
 - Do the changes affect the services you use?
 - Look in Sections 1.2 for information about benefit and cost changes for our plan.
- Check to see if your doctors and other providers will be in our network next year.
 - Are your doctors in our network?
 - What about the hospitals or other providers you use?
 - Look in Section 1.1 for information about our Provider Directory.
- Think about your overall health care costs.
 - How much will you spend out-of-pocket for the services you use regularly?
 - How much will you spend on your deductibles?
 - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at <https://www.medicare.gov> website. Click “Find health & drug plans.”
 - Review the list in the back of your Medicare & You handbook.
 - Look in Section 2.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** Horizon Medicare Advantage NJ DIRECT15 (PPO), you don’t need to do anything. You will stay in Horizon Medicare Advantage NJ DIRECT15 (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don’t join by December 7, 2017**, you will stay in Horizon Medicare Advantage NJ DIRECT15 (PPO).
- If you join by December 7, 2017, your new coverage will start on January 1, 2018.

Additional Resources

- Please contact our Member Services number at **1-800-414-7427** for additional information. (TTY/TDD users should call 711). Hours are Monday through Friday, 8 a.m. to 6 p.m. Eastern.
- This information is also available in alternate formats such as large print.
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

About Horizon Medicare Advantage NJ DIRECT15 (PPO)

Horizon Insurance Company (“HIC”) contracts with CMS to offer group-Medicare Advantage plans and group Part D Prescription Drug plans. Enrollment in HIC Medicare products depends on contract renewal. Products are provided by HIC; however, communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

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When this booklet says "we," "us," or "our," it means Horizon Insurance Company (Horizon) when it says "plan" or "our plan," it means Horizon Medicare Advantage NJ DIRECT15 (PPO).

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Horizon Medicare Advantage NJ DIRECT15 (PPO) in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes* and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.**

Cost	2017 (this year)	2018 (next year)
Deductible	\$100	\$100
	Applies only to non-Medicare eligible services	Applies only to non-Medicare eligible services
Maximum out-of-pocket amounts This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.4 for details.)	For network and Medicare eligible Out-of-Network services: \$5799	For network and Medicare eligible Out-of-Network services: \$5799
	For Out-of-Network non Medicare eligible services: \$2000	For Out-of-Network non Medicare eligible services: \$2000
Doctor office visits	Primary care visits: \$15 per visit	Primary care visits: \$15 per visit
	Specialist visits: \$15 per visit	Specialist visits: \$15 per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	\$200 per inpatient hospital stay for select services not covered under Medicare	\$200 per inpatient hospital stay for select services not covered under Medicare

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at **HorizonBlue.com/doctorfinder**. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.2– Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*.

Changes	2017 (this year)	2018 (next year)
Medicare Diabetes Prevention Program	Medicare Diabetes Prevention Program is not covered	You pay a \$0 copay

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Horizon Medicare Advantage NJ DIRECT15 (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2018.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans please contact the Division of Pensions and Benefits Office at **1-609-292-7524** to cancel your current coverage. They will advise you of other SHBP options. Otherwise you can follow the steps below:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Horizon Medicare Advantage NJ DIRECT15 (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 2.4 of this booklet).
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In *New Jersey*, the SHIP is called *State Health Insurance Assistance Program*.

State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *State Health Insurance Assistance Program* counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *State Health Insurance Assistance Program* at 1-800-792-8820. You can learn more about *State Health Insurance Assistance Program* by visiting their website <http://www.state.nj.us/humanservices/doas/services/ship/>.

SECTION 4 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
 - **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
 - The Social Security Office at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call, **1-800-325-0778** (applications); or
 - Your State Medicaid Office (applications);
- **Help from your state's pharmaceutical assistance program.** New Jersey has two programs called the **New Jersey Department of Human Services Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)**, and the **Senior Gold Lifeline and Special Benefits Programs** that help people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about these programs, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in **Section 4** of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain

criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the New Jersey AIDS Drug Distribution Program (ADDP).

- If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Call 1-877-613-4533, 8:30 a.m. - 5:00 p.m. Monday – Friday, ET or out-of-state coming into New Jersey contact 609-588-7038. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-613-4533, 8:30 a.m. - 5:00 p.m. Monday – Friday, ET or out-of-state coming into New Jersey contact 609-588-7038.

SECTION 5 Questions?

Section 5.1 – Getting Help from Horizon Medicare Advantage NJ DIRECT15 (PPO)

Questions? We're here to help. Please call Member Services at **1-800-414-7427** (TTY/TDD only, call 711.) We are available for phone calls Monday through Sunday, 8:00 a.m. to 6:00 p.m., Eastern. Calls to these numbers are free.

Read your 2018 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for *Horizon Medicare Advantage NJ DIRECT15 (PPO)*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at HorizonBlue.com/shbp. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory).

Section 5.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Visit the Medicare Website

You can visit the Medicare website (<http://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on "Find health & drug plans").

Read *Medicare & You 2018*

You can read the *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Product: **Horizon Medicare Advantage NJ DIRECT15 (PPO)**

Group Name: **State Health Benefits Program- State Government**

Group Number: **095552-015**

January 1 – December 31, 2018

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of

Horizon Medicare Advantage NJ DIRECT15 (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2018. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Horizon Medicare Advantage NJ DIRECT15 (PPO), is offered by Horizon Insurance Company (“HIC”). (When this Evidence of Coverage says “we,” “us,” or “our,” it means Horizon Insurance Company. When it says “plan” or “our Plan,” it means Horizon Medicare Advantage NJ DIRECT15 (PPO).)

Horizon Insurance Company (“HIC”) contracts with CMS to offer group-Medicare Advantage plans and group Part D Prescription Drug plans. Products are provided by HIC however, communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both companies are independent licensees of the Blue Cross and Blue Shield Association.

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Please contact our Member Services number at **1-800-414-7427** for additional information. (TTY/TDD users should call **711**.) Hours are Monday – Friday, between 8:00. a.m. - 6 p.m., ET Member Services also has free language interpreter services available for non-English speakers.

Benefits, deductible, and/or Copayments/Coinsurance may change on January 1, 2019.

Limitations, Copayments and restrictions may apply.

This information is available in large print.

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

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

Chapter 1. Getting started as a member

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Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Horizon Medicare Advantage NJ DIRECT15 (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our Plan, Horizon Medicare Advantage NJ DIRECT15 (PPO).

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

There are different types of Medicare health plans. Horizon Medicare Advantage NJ DIRECT15 (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

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

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of our Plan.

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

If you are confused or concerned or just have a question, please contact our Plan's Member Services (phone numbers are printed on the last page of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

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

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The contract is in effect for months in which you are enrolled in our Plan between January 1, 2018 and December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our Plan after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our Plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- You are a United States citizen or are lawfully present in the United States
- -- *and* -- You do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated.

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

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

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

Chapter 1. Getting started as a member

Section 2.3 Here is the plan service area for our Plan

Although Medicare is a Federal program, our Plan is available only to individuals who live in our Plan service area, which includes all 50 states and Puerto Rico.

If you plan to move out of the service area, please contact the Division of Pensions and Benefits Office at 1-609-292-7524.

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

Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our Plan, you must use your membership card for our Plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable.

As long as you are a member of our Plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get Covered Services using your red, white, and blue Medicare card instead of using your Horizon Medicare Advantage NJ DIRECT15 (PPO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the last page of this booklet.)

Chapter 1. Getting started as a member

Section 3.2 The *Doctor & Hospital Finder*: Your guide to all providers in the plan's network

The *Doctor & Hospital Finder* lists our network providers and durable medical equipment suppliers.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver Covered Services to members in our Plan. The most recent list of providers is available on our website at HorizonBlue.com/shbp.

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

As a member of our Plan, you can choose to receive care from out-of-network providers. Our Plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider for certain services, that are not covered by Medicare but are covered by our Plan, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Doctor & Hospital Finder*, you can request a copy from Member Services (phone numbers are printed on the last page of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Doctor & Hospital Finder* at HorizonBlue.com/shbp, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for our Plan

Section 4.1 How much is your plan premium?

For information regarding your *Horizon Medicare Advantage NJ DIRECT15 (PPO)* premiums, please contact the Division of Pensions and Benefits Office at **1-609-292-7524** or website: www.state.nj.us/treasury/pensions/health-benefits.shtml. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our Plan, you must be entitled to Medicare Part A and enrolled in

Chapter 1. Getting started as a member

Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2018* gives information about these premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

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

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

SECTION 5 Please keep your plan membership record up to date

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

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

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

Let us know about these changes:

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

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- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the last page of this booklet)

Let the Division of Pensions and Benefits Office know about these changes:

- Changes to your name, your address, or your phone number
- If you have been admitted to a nursing home

If any of this information changes, please call the Division of Pension and Benefits Office at 1-609-292-7524.

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

Verifying other insurance coverage you have

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

If needed, we will call your other insurance company to verify the information.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our Plan

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our Plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays

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second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you or your family member 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 that has more than 100 employees.
 - If you’re over 65 and you or your spouse 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 that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

CHAPTER 2

*Important phone numbers and
resources*

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SECTION 1 Our Plan's contacts
 (how to contact us, including how to reach Member Services at the plan)

How to contact our Plan's Member Services

For assistance with claims, billing or member card questions, please call or write to our Plan's Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-800-414-7427 Calls to this number are free. Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 24 hours a day, 7 days a week
WRITE	Horizon Insurance Company Member Services P. O. Box 820 Newark, NJ 07101-0820

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services.

An appeal is a formal way of asking us to review and change a coverage decision we have made.

You can make a complaint about us or a provider, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information on asking for coverage decisions, making appeals or making complaints about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Chapter 2. Important phone numbers and resources

You may call us if you have questions about our coverage decision process, appeals or complaints about your medical care.

Method	Coverage Decisions, Medical Appeals – Contact Information
CALL	1-800-414-7427 Calls to this number are free. Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 24 hours a day, 7 days a week.
FAX	609-583-3028
WRITE	Horizon Medical Appeals 210 Silvia Street West Trenton, NJ 08628
MEDICARE WEBSITE	You can submit a complaint about our Plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

Method	Complaints for Medical Care and Claim Appeals – Contact Information
CALL	1-800-414-7427 Calls to this number are free. Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET.
TTY/TDD	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 24 hours a day, 7 days a week.
FAX	732-938-1340
WRITE	Horizon Medicare Advantage 3 Penn Plaza East, PP-12L Newark, NJ 07105-2200
MEDICARE WEBSITE	You can submit a complaint about our Plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

Chapter 2. Important phone numbers and resources

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

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

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

Method	Payment Requests – Contact Information
CALL	<p>1-800-414-7427</p> <p>Calls to this number are free.</p> <p>Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 24 hours a day, 7 days a week.</p>
WRITE	<p>Horizon Insurance Company Member Services P.O. Box 820 Newark, NJ 07101-0820</p>

Chapter 2. Important phone numbers and resources

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

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

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

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

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Method	Medicare – Contact Information
WEBSITE	<p data-bbox="493 310 824 344">http://www.medicare.gov</p> <p data-bbox="493 359 1425 575">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="493 590 1377 659">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="542 674 1409 940" style="list-style-type: none"> <li data-bbox="542 674 1409 743">• Medicare Eligibility Tool: Provides Medicare eligibility status information. <li data-bbox="542 758 1409 940">• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="493 955 1425 1024">You can also use the website to tell Medicare about any complaints you have about our Plan:</p> <ul data-bbox="542 1039 1377 1297" style="list-style-type: none"> <li data-bbox="542 1039 1377 1297">• Tell Medicare about your complaint: You can submit a complaint about our Plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p data-bbox="493 1312 1425 1528">If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

Chapter 2. Important phone numbers and resources

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New Jersey, the SHIP is called State Health Insurance Assistance Program.

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

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

Method	State Health Insurance Assistance Program (New Jersey SHIP) – Contact Information
CALL	1-800-792-8820
WRITE	State Health Insurance Assistance Program P.O. Box 807 Quakerbridge Plaza Hamilton, NJ 08690-0807
WEBSITE	www.state.nj.us/humanservices/doas/services/ship/

Chapter 2. Important phone numbers and resources

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

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta (New Jersey's Quality Improvement Organization) - Contact Information
CALL	1-866-815-5440 <i>Hours of Operation: Monday – Friday, between 8:00 a.m. – 5:00 p.m.</i>
TTY/TDD	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEBSITE	www.BFCCQIOAREA1.com

Chapter 2. Important phone numbers and resources**SECTION 5 Social Security**

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

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

Method	Social Security – Contact Information
CALL	<p>1-800-772-1213</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p> <p>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</p>
TTY/TDD	<p>1-800-325-0778</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p>
WEBSITE	<p><u>http://www.ssa.gov</u></p>

Chapter 2. Important phone numbers and resources

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

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

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

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

Method	New Jersey Department of Human Services – Contact Information
CALL	1-800-356-1561 <i>Hours of Operation: Monday – Friday, between 8:30 a.m. – 4:45 p.m.</i>
WRITE	Please contact your local county’s welfare agency (Board of Social Services).
WEBSITE	<u>www.state.nj.us/humanservices/dmahs/clients/medicaid/abd/NJ_County_Welfare_Agencies.pdf</u>

Chapter 2. Important phone numbers and resources**SECTION 7 How to contact the Railroad Retirement Board**

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

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

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>Available 9:00 am to 3:30 pm, Monday through Friday</p> <p>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</p>
TTY/TDD	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
WEBSITE	<p>http://secure.rrb.gov</p>

Chapter 2. Important phone numbers and resources

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the last page of this booklet.) You may also call **1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048)** with questions related to your Medicare coverage under this plan.

CHAPTER 3

*Using the plan's coverage for your
medical services*

Chapter 3. Using the plan’s coverage for your medical services

Chapter 3. Using the plan’s coverage for your medical services

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

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

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

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

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

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network or In-Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us or another Blue Plan to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our Plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **“Out-of-Network providers”** are doctors and other health care professionals, medical groups, hospitals, and other health care facilities that do NOT have an agreement with us or another Blue Plan to accept our payment.
 - If you use an out-of-network provider for **Medicare eligible** services, your cost share will be the same as if you had used an in-network provider.
 - If you use an out-of-network provider for services that are **not Medicare eligible**, your cost share may be higher than if you had used an in-network provider.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare and agree to provide health care services to our Plan members. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our Plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2	Basic rules for getting your medical care covered by the plan
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As a Medicare health plan, our Plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our Plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter). You may access both in-network and out-of-network providers for Medicare eligible services without any difference in Copayment or Coinsurance.
 - The providers in our network are listed in the *Doctor & Hospital Finder*.
 - If you use an out-of-network provider for services not eligible for Medicare payments (services that are not covered by Medicare but covered by our Plan), your share of the costs for your covered services may be higher.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare and agree to provide health care services to our Plan members. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

Section 2.1	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.

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

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

Under our Plan, there is no requirement to select a Primary Care Provider to oversee your care. You do not need referrals to see a specialist. Please note, the General Practitioner Copayment will apply when you see an in-network provider or a provider, who is eligible to receive Medicare payments, practicing primary care such as a: **General Practice, Family Practice, or Internal Medicine**. If you see **any other type of doctor**, the specialist Copayment will apply.

For some types of services, your general practitioner or specialist may need to get approval in advance from our Plan (this is called getting "prior authorization"). If your general practitioner or specialist determines that a prior authorization is needed, they will contact the plan at **1-855-742-7861**. Please refer to Chapter 4 for services that require prior authorization from our Plan.

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

We may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our Plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out that your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

To obtain care from a different provider, you may access our online directory at **HorizonBlue.com/shbp**. You may also contact Member Services (phone numbers are printed on the last page of this booklet).

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

As a member of our Plan, you can choose to receive care from out-of-network providers. For a definition of “out-of-network” provider, see Chapter 3 Section 1.1, *What are “network providers” and “covered services”?* However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our Plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. You may access both in-network and out-of-network providers for Medicare eligible services without any difference in cost share. However, you need to use a licensed provider that accepts Medicare and the provider must agree to provide services. Generally your cost share in-network and out-of-network will be the same. **If you use an out-of-network provider for certain services not eligible for Medicare payment (services not covered by Medicare), your cost share may be higher as compared to an in-network provider.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services (our share of the cost for covered services is based on the amount that CMS would pay the provider). Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement. If the out-of-network provider requires you to pay upfront, we encourage you to see an in-network provider instead so you do not have to pay up front. Our Plan does not allow participating providers to balance bill you for covered Medicare Eligible services. See Chapter 4, Section 1.5 for more information on this protection.
- If you are using an out-of-network provider for emergency care, urgently needed services or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your general practitioner.

What is covered if you have a medical emergency?

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

Coverage for emergency care is worldwide. Please refer to the Benefits Chart in Chapter 4, for more information about this benefit.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our Plan. If you get your follow-up care from out-of-network providers, you may pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

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

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

However, after the doctor has said that it was *not* an emergency; the amount of cost-sharing that you pay may depend on whether you get the care from a network provider or an out-of-network provider. If the services you received are not Medicare eligible, your share of the costs may be lower with an in-network provider than with an out-of-network provider.

Section 3.2 Getting care when you have an urgent need for services**What are “urgently needed services”?**

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

What if you are outside the plan's service area when you have an urgent need for care?

Our Plan has a national service area. When you are outside the service area (i.e., outside of the United States) and cannot get care from a network provider, our Plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Section 3.3 Getting care during a disaster

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

Please visit the following website: HorizonBlue.com/shbp for information on how to obtain needed care during a disaster.

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

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

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

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

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

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

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

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

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the last page of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Costs incurred once a benefit limit is reached do not count towards the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

Not all clinical research studies are open to members of our Plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our Plan and continue to get the rest of your care (the care that is not related to the study) through our Plan.

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

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

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

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

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

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

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

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<http://www.medicare.gov>). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2	What care from a religious non-medical health care institution is covered by our Plan?
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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

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

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

You are covered for unlimited inpatient hospital care days, as long as your stay satisfies the Medicare coverage guidelines. Please refer to the Benefits Chart in Chapter 4 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our Plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying Copayments for the item for 13 months. As a member of our Plan, however, you will own certain equipment, such as walkers, wheelchairs, hospital beds, etc. at the time of purchase or after paying Copayments for 10 months of rental. There is some equipment that is frequently serviced, such as ventilators, that you will not acquire ownership of no matter how many Copayments you make for the item while a member of our Plan. To see if these circumstances apply, please speak with your general practitioner or medical equipment supplier about ownership of the rented durable medical equipment. They can determine if you meet the requirements and what documentation must be provided.

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

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

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

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

Chapter 4

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

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

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

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

Section 1.1	Types of out-of-pocket costs you may pay for your covered services
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To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

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

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

Section 1.2	What is your plan deductible?
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Your deductible is **\$100**. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. The deductible applies only to select out-of-network services that are not covered by Medicare but they are covered by our Plan. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your Coinsurance amount) for the rest of the calendar year.

The deductible does not apply to Medicare eligible services. For those services that are not covered by Medicare but are covered by our Plan, the deductible does not apply if you receive such services from an in-network provider. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet.

Section 1.3 Our plan has a separate deductible for certain types of services from out-of-network providers

In addition to the plan out-of-network deductible that applies to select services not covered by Medicare but covered by our Plan, we also have a separate out-of-network deductible for certain types of services.

The plan has a **\$200** deductible per inpatient hospital stay for select services not covered under Medicare. Once you have paid your deductible, we will pay our share of the costs for these services and you will pay your share (your Coinsurance amount) for the rest of your inpatient stay. The inpatient hospital deductible for select services not covered under Medicare is applied only if there has been at least 90 days since your last admission.

Section 1.4 What is the most you will pay for covered medical services?

Under our Plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- For all in-network and Medicare eligible out-of-network services, your **maximum out-of-pocket** amount is **\$5799**. This is the most you pay during the calendar year for all in-network and Medicare eligible out-of-network services. The amounts you pay for Copayments and Coinsurance for these services count toward this maximum out-of-pocket amount. If you have paid **\$5799** for all in-network and Medicare eligible out-of-network services, you will not have any out-of-pocket costs for the rest of the year for Medicare covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B Premium is paid for you by Medicaid or another third party).
- For out-of-network services that are not Medicare eligible, your **maximum out-of-pocket amount** is **\$2000**. This is the most you pay during the calendar year for out-of-network services that are not Medicare eligible. The amounts you pay for deductibles and Coinsurance for these services count toward this out-of-network maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your out-of-network maximum out-of-pocket amount). If you have paid **\$2000** for out-of-network services that are not Medicare eligible, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for these covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Participating providers outside our service area - Your liability calculation

When you receive covered services outside of our service area from an in-network provider, the cost of the service, on which your liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services; or

- The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Nonparticipating providers outside our service area

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

Section 1.5	Our Plan also limits your out-of-pocket costs for certain types of services
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In addition to the maximum out-of-pocket amounts for covered services (see Section 1.4 above), we also have a separate maximum out-of-pocket amount that applies only to select services that are subject to Coinsurance. These services are in-network Outpatient Private Duty Nursing and in-network or out-of-network Ambulance, DME and some prosthetic and orthotic services.

The Plan has a maximum out-of-pocket amount of **\$400** for these select services that are subject to Coinsurance. Once you have paid **\$400** out-of-pocket for these select services subject to Coinsurance, the Plan will cover these services at no cost to you for the rest of the calendar year. Both the maximum out-of-pocket amount for all in-network and Medicare eligible out-of-network covered medical services and the maximum out-of-pocket amount for these select services subject to Coinsurance apply to these select covered services. This means that once you have paid either **\$5,799** for all in-network and Medicare eligible out-of-network covered medical services or **\$400** for these select services subject to Coinsurance, the Plan will cover these select services at no cost to you for the rest of the year.

Section 1.6	Our Plan does not allow providers to "balance bill" you for covered Medicare eligible services
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As a member of our Plan, an important protection for you is that you only have to pay your cost-sharing amount when you get Medicare eligible services covered by our Plan. We do not allow providers to add additional separate charges, called "Balance Billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

- If your cost-sharing is a Copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher Copayments when you obtain care from out-of-network providers.
- If your cost-sharing is a Coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the Coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the Coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the Coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the last page of this booklet).

Please note there are some plan covered services that are not Medicare eligible and are excluded from this protection. When you receive services that are not Medicare eligible you may be balanced billed. Please see the back of the Medical Benefits Chart for these services that are not Medicare eligible but are covered by our Plan.

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

Section 2.1	Your medical benefits and costs as a member of the plan
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The Medical Benefits Chart on the following pages lists the services our Plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from our Plan.

- Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
 - **Cognitive Therapy**
 - **Eyelid Surgery**
 - **Gastric Bypass/Bariatric Procedures**
 - **Home Infusion Services**
 - **Hyperbaric Oxygen Therapy**
 - **Pain Management Injections**
 - **Procedures that could be considered cosmetic**
 - **Religious Non-Medical Health Care Institutions (RNHCI)**
 - **Sinus and Nasal Surgery**
 - **Surgery for Sleep Apnea (e.g., Uvulopalatopharyngoplasty (UPPP)/ Uvulopalatoplasty (UPP))**
 - **Temporomandibular Joint (TMJ) and Jaw Surgery**
 - **Transgender Surgery**
 - **Transplant Services/ Organ Transplants except Corneal Transplants**
 - **Varicose Vein Surgery**
- You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a Coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you pay the Coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the Coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the Coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our Plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018 Handbook*. View it online at <http://www.medicare.gov> or ask for a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**).

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

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a Copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our Plan will cover those services.
- As a member of our Plan, you may access both in-network and out-of-network providers for Medicare eligible services without any difference in Copayment or Coinsurance. However, you need to use a licensed provider that accepts Medicare and agrees to provide services to you. If you use an out-of-network provider for certain services that are not Medicare eligible, your cost share may be higher. These services that are not Medicare eligible are listed at the back of the Medical Benefits Chart.








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



Medical Benefits Chart




Original Medicare covered services


The following Medicare eligible services are covered under our Plan. You may access both in-network and out-of-network providers for Medicare eligible services without any difference in Copayment or Coinsurance. However, for out-of-network providers, you need to use a licensed provider that accepts Medicare and agrees to provide services to you. For definitions of “in-network” and “out-of-network” provider, please see Chapter 3 section 1.1 *What are “Network providers” and “covered services”?*


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Covered in Full.
Ambulance services <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required. • Emergency transportation is covered worldwide when you are temporarily outside of the United States and its territories. <p>Except in an emergency, for in-network services prior authorization must be obtained by your network provider for air, ground and non-emergency ambulance services.</p>	Subject to 10% Coinsurance up to \$400 Maximum for Emergency and Non-Emergency Ambulance services (One Way).

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Annual wellness visit (Routine physical exam)</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	<p>Covered in Full.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>Covered in Full.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram under the age of 40 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>Covered in Full.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>Subject to a \$15 Copayment.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover visits with your primary care doctor to help lower your risk for cardiovascular disease. During these visits, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating well.</p>	<p>Covered in Full.</p>



Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
 Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	Covered in Full.
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 12 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and or have had an abnormal Pap test one Pap test every 12 months, unless additional tests are medically needed at the appropriate level of care for diagnostic purposes • Human Papillomavirus (HPV) testing once every 12 months for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test 	Covered in Full.
Chiropractic services Covered services include: <ul style="list-style-type: none"> • We cover manual manipulation of the spine to correct subluxation 	Subject to a \$15 Copayment per visit <i>Combined Medicare and Non Medicare covered - 30 visit maximum benefit per calendar year</i>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 12 months <p>One of the following every 12 months</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every year</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 12 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 12 months 	<p>Covered in Full.</p>
<p> Depression screening</p> <p>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 referrals.</p>	<p>Covered in Full.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>Covered in Full.</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none">• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.• Diabetes self-management training is covered under certain conditions.• Benefits, limited to four visits per year, are included for expenses incurred for diabetes self-management education to ensure that a person with diabetes is educated as to the proper self-management and treatment of the member's condition. <p>Benefits for self-management education and education relating to diet shall be limited to medically necessary visits upon:</p> <ul style="list-style-type: none">• The diagnosis of diabetes;• The diagnosis by a physician or nurse provider/clinical nurse specialist of a significant change in your symptoms or conditions which necessitate changes in your self-management; and• Determination by a physician or nurse provider/clinical nurse specialist that reeducation or refresher education is necessary. <p>Diabetes self-management education is covered when provided by:</p> <ul style="list-style-type: none">• A physician, nurse provider, or clinical nurse specialist;	<p>Covered in Full.</p> <p>If you obtain diabetic supplies from a pharmacy, you may have to pay out-of-pocket. You can then submit your claim to us for reimbursement.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies (continued)</p> <ul style="list-style-type: none">• A health care professional such as a registered dietician that is recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or• A registered pharmacist qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy. <p>Benefits are provided for expenses incurred for insulin pumps for the treatment of diabetes, if recommended or prescribed by a physician or nurse provider/clinical nurse specialist.</p> <p>For in-network services prior authorization must be obtained by your network provider for supplies, therapeutic shoes and inserts</p>	
<p>Durable medical equipment and related supplies (For a definition of “durable medical equipment,” Chapter 10 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital bed, ordered by a provider for use in the home, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at HorizonBlue.com/shbp.</p> <p>For in-network services prior authorization must be obtained by your network provider for all durable medical equipment and supplies.</p>	<p>Subject to 10% Coinsurance up to \$400 Maximum</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none">• Furnished by a provider qualified to furnish emergency services, and• Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Coverage is provided worldwide when you are temporarily outside of the United States.</p>	<p>Subject to a \$75 Copayment for emergency care.</p> <p>Copayment waived if admitted within 24 hours for the same condition.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>Subject to a \$15 Copayment for Specialist visit</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Hepatitis C Virus (HCV) Screening in Adults</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Screening test for adults at high risk for Hepatitis C Virus infection. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.• Single screening test is covered for adults who are not high risk, but who were born from 1945 through 1965.• Screening test covered for those who had a blood transfusion before 1992. <p>Services eligible only when ordered by the member's general practitioner.</p>	<p>Covered in Full.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none">• One screening exam every 12 months. <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none">• Up to three screening exams during a pregnancy. <p>Screening for HIV is covered for individuals entitled to benefits between the ages of 15 and 65 years of age.</p>	<p>Covered in Full.</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>A prior inpatient hospital stay is not required to qualify for home health care agency benefits but you must be homebound and require skilled nursing care under a plan prescribed by an attending physician.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>For in-network services prior authorization must be obtained by your network provider for all home health services and supplies.</p>	<p>Covered in Full.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our Plan.</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Hospice care (continued)</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our Plan’s network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. <p><u>For services that are covered by our Plan but are not covered by Medicare Part A or B:</u> our Plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>Covered in Full.</p> <p>If you obtain covered services from a pharmacy, you may have to pay out-of-pocket. You can then submit your claim to us for reimbursement.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</p> <p>There is no limit to the number of days covered by the Plan for each hospital stay. Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Semi-private room (or a private room if medically necessary)• Meals including special diets• Regular nursing services• Costs of special care units (such as intensive care or coronary care units)• Drugs and medications• Lab tests• X-rays and other radiology services• Necessary surgical and medical supplies• Use of appliances, such as wheelchairs• Operating and recovery room costs• Physical, occupational, and speech language therapy• Inpatient alcohol and substance abuse services	<p>Covered in Full</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none">• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.• Blood including storage and administration. Coverage begins with the first pint of blood that you need.• Physician services. <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Except in an emergency, for in-network services prior authorization must be obtained by your network provider from Horizon.</p>	<p>Re-admission for the same diagnosis within three days of discharge constitutes a continuation of the initial stay.</p>
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>Contact the Horizon behavioral health program at 1-800-626-2212, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY/TDD users should call 1-888-540-7313.</p> <p>Except in an emergency, prior authorization must be obtained by a network provider.</p>	<p>Covered in Full</p> <p>Subject to a \$0 Copayment per lifetime reserve day</p> <p>Re-admission for the same diagnosis within three days of discharge constitutes a continuation of the initial stay.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay are not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Physician services.• Diagnostic tests (like lab tests).• X-ray, radium, and isotope therapy including technician materials and services.• Surgical dressings.• Splints, casts and other devices used to reduce fractures and dislocations.• Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.• Physical therapy, speech therapy, and occupational therapy. <p>For in-network services, your network provider must obtain prior authorization for certain services.</p>	<p>You are covered for these services according to Medicare guidelines.</p> <p>You pay applicable Copayments or Coinsurance listed in the Benefits Chart for covered services received.</p> <p>Cost-sharing is listed below for each Medicare-covered service (see the referenced sections for more detailed information):</p> <p>See "Physician/ Practitioner services, including doctor's office visits" for more detail on the following:</p> <p>Subject to a \$15 Copayment for each PCP office visit</p> <p>Subject to a \$15 Copayment for each specialist office visit</p> <p>See "Outpatient diagnostic tests and therapeutic services and supplies" for more detail on the following:</p> <p>Laboratory services Covered in Full</p> <p>Subject to a \$0 Copayment for each Ambulatory Surgical Center visit</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (Continued)</p>	<p>Subject to a \$0 Copayment for each Outpatient Hospital visit including chemotherapy and radiation therapy.</p> <p>Specialist Copayment for services rendered at a Free Standing Radiology Center.</p> <p>See "Prosthetic devices and related supplies" for more detail on the following:</p> <p>Subject to a \$15 Copayment for prosthetics or 10% Coinsurance for prosthetics that fall under the Mandate.</p> <p>See "Outpatient rehabilitation services" for more detail on the following:</p> <p>Subject to a \$15 Copayment for physical therapy, speech therapy, and occupational therapy.</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We allow three visits per year for nutritional counseling that is medically needed and at the appropriate level of care. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>Covered in Full.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Medicare Diabetes Prevention Program (MDPP) Beginning April 1, 2018, MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p>	Covered in Full.

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our Plan receive coverage for these drugs through our Plan. Covered drugs include:</p> <ul style="list-style-type: none">• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan.• Clotting factors you give yourself by injection if you have hemophilia.• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.• Antigens.• Certain oral anti-cancer drugs and anti-nausea drugs.• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. <p>Prior authorization must be obtained by your in network provider for certain injectable and specialty pharmaceuticals, such as those used to treat rare disease, Multiple Sclerosis, rheumatoid arthritis, psoriatic arthritis, psoriasis, cancer, anemia, Crohn's disease, ulcerative colitis, Flolan and derivatives, and Xolair from Magellan Rx Management.</p>	<p>Covered in Full</p> <p>If you obtain covered Medicare Part B drugs from a pharmacy, you may have to pay out-of-pocket. You can then submit your claim to us for reimbursement.</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	Covered in Full.
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• X-rays• Radiation (radium and isotope) therapy including technician materials and supplies• Surgical supplies, such as dressings• Splints, casts and other devices used to reduce fractures and dislocations• Laboratory tests• Blood - including storage and administration. Coverage begins with the first pint of blood that you need• Other outpatient diagnostic tests (pre admission diagnostic X-ray and laboratory tests needed for a planned hospital admission or surgery is covered). <p>For in-network services prior authorization must be obtained by your network provider for radiation therapy, advanced imaging services (such as MRI, MRA, Nuclear Medicine, PET, CT Scans, Echocardiogram, and Cardiac Catheterization) and pain management services.</p>	Covered in Full


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery• Laboratory and diagnostic tests billed by the hospital• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it• X-rays and other radiology services billed by the hospital• Medical supplies such as splints and casts• Certain drugs and biologicals that you can't give yourself• Hemophilia treatment <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Your provider must obtain prior authorization for certain in-network services.</p>	<p>Subject to 0% Coinsurance for services you get in the outpatient department of a hospital, except for the following:</p> <p>Cost-sharing on Laboratory Services associated with Dialysis in an Outpatient Hospital setting is waived.</p> <p>Subject to a \$75 Copayment per Emergency department visit. Please see "Emergency care" for more information.</p> <p>Subject to a \$15 Copayment for each mental health care visit. Please see "Outpatient mental health care" for more information.</p> <p>Subject to a \$0 Copayment for Partial hospitalization services. Please see "Partial hospitalization services" for more information.</p> <p>Covered in Full for Medicare covered preventive services</p>



Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Contact the Horizon behavioral health program at 1-800-626-2212, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY/TDD users should call 1-888-540-7313. Except in an emergency, for in-network services prior authorization must be obtained by your network provider for certain services.</p>	<p>Subject to a \$15 Copayment for each authorized individual/group therapy visit. Subject to a \$0 Copayment for each Outpatient Hospital Facility visit.</p>
<p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Physical/Occupational Therapy that is medically needed and at the appropriate level of care is covered based on one session per day. A session of therapy is defined as up to one hour of therapy (treatment and/or evaluation) or up to three therapy modalities provided on any given day. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). For in-network services prior authorization must be obtained by your network provider for all therapy services and additional visits.</p>	<p>Subject to a \$15 Copayment for each office visit. Subject to a \$0 Copayment for each Outpatient Hospital Facility visit.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Outpatient alcohol and substance abuse services</p> <p>Coverage for 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 alcohol and substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.</p> <p>Contact the Horizon behavioral health program at 1-800-626-2212, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY/TDD users should call 1-888-540-7313.</p> <p>Except in an emergency, for in-network services prior authorization must be obtained by your network provider for certain services.</p>	Covered in Full
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p>For certain in-network surgical procedures prior authorization must be obtained by your network provider. Please refer to Section 2.1 of this Chapter for a list of services requiring prior authorization.</p>	Covered in Full

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p>Contact the Horizon behavioral health program at 1-800-626-2212, between 8:00 a.m. and 8:00 p.m., ET, for routine services; 24 hours a day, 7 days a week, for emergencies. TTY/TDD users should call 1-888-540-7313.</p> <p>Except in an emergency, if partial hospitalization involves mental health care or alcohol and substance abuse, for in-network services prior authorization must be obtained by your network provider.</p>	<p>Covered in Full</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician’s office certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your general practitioner, if your doctor orders it to see if you need medical treatment. • Second opinion by another network provider prior to surgery. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). 	<p>Subject to a \$15 Copayment for General Practitioner visit.</p> <p>Subject to a \$15 Copayment for Specialist visit.</p> <p>Subject to a \$0 Copayment for each Ambulatory Surgical Center visit.</p> <p>Subject to a \$0 Copayment for each Outpatient Hospital facility visit, including chemotherapy and radiation therapy.</p>


Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>Subject to a \$15 Copayment for Specialist visit</p>
<p> Prostate cancer screening exams For men age 40 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>Covered in Full.</p>
<p>Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>For in-network services prior authorization must be obtained by your network provider for all prosthetic devices and related supplies.</p> <p>*Please call Member Services to determine if a device falls under the Prosthetics/Orthotics Mandate.</p>	<p>Subject to a 10% Coinsurance up to \$400 Maximum</p> <p>Subject to a \$15 Copayment which applies for prosthetics/orthotics that fall under the *Prosthetics/Orthotics Mandate.</p>
<p>Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and <i>an order</i> for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>Subject to a \$15 Copayment for visit.</p>



Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Scalp Hair Protheses (Wigs) A benefit maximum of \$500 in a 24-month period, per person, is covered for scalp hair protheses (wig) prescribed by a doctor, only if they are furnished in connection with hair loss resulting from:</p> <ul style="list-style-type: none">• Treatment of disease by radiation or chemicals;• Alopecia Universalis (totalis); or• Alopecia Areata.	<p>You pay any excess amounts above the \$500 maximum in a 24-month period</p>
<p> Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>Covered in Full.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</i></p>	<p>Covered in Full.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</p>	<p>Covered in Full.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)• Home dialysis equipment and supplies• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</p>	<p>Subject to a \$15 Copayment for kidney disease education services</p> <p>Covered in Full for Renal Dialysis services including Outpatient dialysis treatments, equipment, supplies and certain home support services. See Inpatient Hospital Services for applicable Inpatient Copayments.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>This benefit is limited to a maximum of 120 days per Benefit Period. No prior hospital stay is required. Custodial care or domiciliary care in a skilled nursing facility is not covered.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Semiprivate room (or a private room if medically necessary)• Meals, including special diets• Skilled nursing services• Physical therapy, occupational therapy, and speech therapy• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)• Blood - including storage and administration- Coverage begins with the first pint of blood that you need• Medical and surgical supplies ordinarily provided by SNFs• Laboratory tests ordinarily provided by SNFs• X-rays and other radiology services ordinarily provided by SNFs• Use of appliances such as wheelchairs ordinarily provided by SNFs• Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our Plan's amounts for payment.</p> <ul style="list-style-type: none">• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).• A SNF where your spouse is living at the time you leave the hospital. <p>For in-network services prior authorization must be obtained by your network provider</p>	<p>Covered in Full</p> <p>You are covered for up to 120 days each Benefit Period. A new Benefit Period begins each time you are not readmitted to a SNF for 90 consecutive days since your last discharge. There is no annual limit to the number of benefit periods.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>Covered in Full.</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Coverage is provided worldwide when you are temporarily outside of the United States.</p>	<p>Subject to a \$15 Copayment for each visit.</p> <p>Worldwide coverage:</p> <p>Subject to a \$75 Copayment for worldwide coverage.</p> <p>Copayment waived if admitted to a hospital within 24 hours for the same condition.</p>

Medicare eligible services rendered by a network provider or other licensed provider that accepts Medicare.	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.• For people with diabetes, screening for diabetic retinopathy is covered once per year.• No benefit for frames, lenses, or contact lenses. Contact lens fitting examinations are not covered.• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	<p>Subject to a \$15 Copayment for Specialist visit.</p> <p>Subject to a \$0 Copayment for Glaucoma screenings and Annual Diabetic Retinal Exam.</p> <p>Subject to a \$0 Copayment for one pair of eyeglasses or contact lenses after each cataract surgery is covered. The eyeglasses or contact are covered and reimbursed at 100% of Medicare allowance.</p>
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>Covered in Full.</p>

Non-Medicare covered services

The following services are covered under our Plan, but are not covered by Original Medicare. If you use an out-of-network provider for these non-Medicare services, your cost share may be higher. For definitions of “in-network” and “out-of-network” provider, please see Chapter 3 section 1.1 *What are “Network providers” and “covered services”?*

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p>Acupuncture Services (Pain Management only)</p> <p>Acupuncture treatment is covered when the services are for a diagnosis related to pain management and are rendered by a Licensed Acupuncturist or Licensed Medical Doctor (M.D., D.O.). Acupuncture treatment is subject to maintenance and supportive care provisions.</p> <p>Examples of acupuncture services that are not eligible under our Plan include weight loss and smoking cessation.</p>	<p>In-Network:</p> <p>Subject to a \$15 Copayment for Specialist visit</p> <p>Out-of-Network:</p> <p>Subject to a 30% Coinsurance after satisfying the \$200 Deductible per stay if performed at an Inpatient Facility. This amount applies only if it has been at least 90 days since your last admission. Otherwise \$100 deductible applies</p> <p>(Horizon allowance limited to \$60 per visit)</p>
<p>Autism</p> <p>We provide:</p> <ul style="list-style-type: none"> • Coverage for expenses incurred in screening and diagnosing autism or another developmental disability; • Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability; • Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals diagnosed with autism; <p>For in network services, prior authorization must be obtained for certain services.</p>	<p>In-Network:</p> <p>Subject to a \$15 Copayment for Specialist visit</p> <p>Out-of-Network:</p> <p>Subject to a 30% Coinsurance after satisfying the \$200 Deductible per stay if performed at an Inpatient Facility. This amount applies only if it has been at least 90 days since your last admission. Otherwise \$100 deductible applies.</p>

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p>Chiropractic services The chiropractor must be licensed, the services must be appropriate for the diagnosed condition(s), and must fall within the scope of practice of a chiropractor in the state in which he or she is practicing. Chiropractic services are subject to a medical necessity review process.</p>	<p>In-Network Subject to a \$15 Copayment.</p> <p>Out-of-Network Subject to a 30% Coinsurance after satisfying the \$200 Deductible per stay if performed at an Inpatient Facility. This amount applies only if it has been at least 90 days since your last admission. Otherwise \$100 deductible applies (Horizon allowance limited to \$35 per visit) <i>Combined Medicare and Non-Medicare covered -30 visit maximum benefit per calendar year</i></p>
<p>Hearing services Routine hearing exam is limited to 1 exam every year. Hearing aids are not covered</p>	<p>In-Network Covered in Full</p> <p>Out-of-Network Covered in Full</p>

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p>Infertility services</p> <p>Charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy (including microsurgical sperm aspiration); laboratory tests; sperm washing or preparation; diagnostic evaluations; assisted hatching; fresh and frozen embryo transfer; ovulation induction; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF), including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate; zygote intrafallopian transfer (ZIFT); artificial insemination; intracytoplasmic sperm injection (ICSI); and the services of an embryologist. This benefit includes diagnosis and treatment of both male and female infertility.</p> <p>Eligibility Requirements</p> <p>Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:</p> <ul style="list-style-type: none">• Impregnate another person;• Conceive after two years if the female partner is under 35 years old, or after one year if the female partner is 35 years old or older, or if one partner is considered medically sterile; or• Carry a pregnancy to live birth. <p>In vitro fertilization, gamete transfer and zygote transfer services are covered only:</p> <ul style="list-style-type: none">• If you have used all reasonable, less expensive and medically appropriate treatment and are still unable to become pregnant or carry a pregnancy;• Up to four completed egg retrievals combined. Egg retrievals covered by another plan or the member (outside of our Plan) will not be applied toward our Plan limit for infertility services; and <p style="padding-left: 40px;">If you are 45 years old or younger.</p>	<p>In-Network</p> <p>Covered in Full</p> <p>Out-of-Network</p> <p>Subject to a 30% Coinsurance after satisfying the \$200 Deductible per stay if performed at an Inpatient Facility. This amount applies only if it has been at least 90 days since your last admission. Otherwise \$100 deductible applies.</p>

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p data-bbox="203 346 617 378">Infertility services (continued)</p> <p data-bbox="203 388 438 420">Covered Expenses</p> <ul data-bbox="203 451 974 1092" style="list-style-type: none">• Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist.• Intracytoplasmic sperm injections.• In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate.• Ovulation induction.• Surgery, including microsurgical sperm aspiration.• Artificial Insemination.• Assisted Hatching.• Diagnosis and diagnostic testing.• Fresh and frozen embryo transfers. <p data-bbox="203 1113 349 1144">Exclusions</p> <p data-bbox="203 1165 958 1197">The following are specifically excluded infertility services:</p> <ul data-bbox="203 1218 941 1575" style="list-style-type: none">• Reversal of male and female voluntary sterilization.• Infertility services when the infertility is caused by or related to voluntary sterilization.• Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist.• Cryopreservation is not a covered benefit.	

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p>Infertility services (continued)</p> <ul style="list-style-type: none"> • Any experimental, investigational, or unproven infertility procedures or therapies. • Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier’s policy or contract. • Ovulation kits and sperm testing kits and supplies. • In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older. Egg retrievals covered by another plan or the member (outside of our Plan) will not be applied toward our Plan limit for infertility services. • Costs associated with egg or sperm retrieval not related to an authorized IVF procedure. <p>For in-network services, prior authorization must be obtained by your network provider for certain services.</p>	
<p>Nurse Line</p> <ul style="list-style-type: none"> • A confidential service that enables you to speak with a registered nurse, toll free 24 hours a day to assist with health-related questions and concerns. <p>Please call 1- 866-901-7477 to contact the 24/7 Nurse Line.</p>	<p>In-Network Covered in Full</p> <p>Out-of-Network Covered in Full</p>

Services that are covered for you but are not covered by Original Medicare	What you must pay when you get these services
<p>Outpatient private duty nursing</p> <p>Private Duty Nursing (PDN) is covered subject to Horizon BCBSNJ medical policy. PDN is characterized by the performance of skilled services by a licensed nursing professional (RN/LPN) in the member’s home typically to take the place of continued in-patient treatment. PDN will be part of a written short term, home care plan leading to the training of the primary care giver(s) to deliver those services once the member's condition is stabilized. PDN is not meant to replace a parent or caregiver, but is meant to provide skilled support to the member at home when such services are medically necessary to properly attend the member.</p> <p>According to Horizon BCBSNJ medical policy PDN is considered medically necessary for members who are on ventilators when the physician or specialist has agreed to a home care plan, the member meets medical necessity criteria for confinement in a Skilled Nursing Facility and placement of the nurse in the home is done to meet the skilled needs of the member only; not for the convenience of the family caregiver. Upon initial discharge of a ventilator dependent member from an inpatient setting, up to 24 hours PDN per day may be covered for a period of up to three weeks to facilitate transition to home. Thereafter, up to a maximum of 16 hours of PDN per day may be considered medically necessary. Payment for any additional home nursing care is the sole responsibility of the member/family.</p> <p>For in-network services, prior authorization must be obtained by your network provider.</p>	<p>In-Network</p> <p>Subject to 10% Coinsurance up to \$400 Maximum</p> <p>Out-of-Network</p> <p>Subject to a 30% Coinsurance after satisfying \$100 annual Deductible.</p>
<p>Vision care</p> <p>Routine eye exam</p> <p>Limited to 1 exam every year</p>	<p>In-Network</p> <p>Covered in Full</p> <p>Out-of-Network</p> <p>Covered in Full</p>

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do <i>not</i> cover (exclusions)
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This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by our Plan and Original Medicare to not be generally accepted by the medical community.</p>		<p>✓</p> <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our Plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Hearing aids or exams to fit hearing aids.	✓	
Private room in a hospital.		<p>✓</p> <p>Covered only when medically necessary.</p>
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	<p>✓</p> <p>May be covered for a short term to take place of continued in-patient treatment to deliver PDN services until member condition is stabilized. Must meet all the criteria and medical necessity.</p>
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	√	
Fees charged for care by your immediate relatives or members of your household.	√	
Cosmetic surgery or procedures		<p style="text-align: center;">√</p> <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.	√	
Non-routine dental care.		<p style="text-align: center;">√</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Routine foot care		<p style="text-align: center;">√</p> <p>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.</p>
Home-delivered meals	√	
Orthopedic shoes		<p style="text-align: center;">√</p> <p>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</p>

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

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

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

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

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

Section 1.1	If you pay our Plan’s share of the cost of your covered services, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our Plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our Plan whenever you’ve paid more than your share of the cost for medical services that are covered by our Plan. **Our reimbursement to you for covered services would be up to the amount CMS would pay the provider.**

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

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

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

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

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

- You only have to pay your cost-sharing amount when you get services covered by our Plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.5
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our Plan.

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

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

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

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

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

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

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

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

- You don't have to use the form, but it will help us process the information faster.

Either download a copy of the form from our website at (**HorizonBlue.com/shbp**) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the last page of this booklet.)

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

For Medical Care:
Horizon Insurance Company
Member Services
P. O. Box 820
Newark, NJ 07101-0820

You must submit your claim to us within one year of the date you received the service, item, or Part B drug.

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

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

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2	If we tell you that we will not pay for all or part of the medical care, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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Chapter 6. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in large print)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the last page of this booklet).

Our Plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in large print if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the last page of this booklet) or contact the Coordinator of Civil Rights.

If you have any trouble getting information from our Plan in a format that is accessible and appropriate for you, please call to file a grievance with our Plan at **1-800-414-7427** (TTY/TDD users may call **711**). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Member Services for additional information.

Section 1.2 We must treat you with fairness and respect at all times

Our Plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights at 1-800-368-1019 (TTY/TDD 1-800-537-7697)** or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the last page of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services

You have the right to choose a provider for your care.

Chapter 6. Your rights and responsibilities

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

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

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us

Chapter 6. Your rights and responsibilities

to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the last page of this booklet).

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of our Plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in large print.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the last page of this booklet):

- **Information about our Plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's 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.**
 - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Doctor & Hospital Finder.
 - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the last page of this booklet) or visit our website at HorizonBlue.com/shbp.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the last page of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this

Chapter 6. Your rights and responsibilities

explanation even if you received the medical service from an out-of-network provider.

- If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our Plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

We also review new medical technology for the purpose of deciding its eligibility for coverage. This broad process includes input from the professional and medical community, including input from doctors and other health care professionals in New Jersey, as well as the results of literature research such as newspapers, books and magazines. In addition, we review current policies about existing technology and change them as necessary.

Section 1.6	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

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

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

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

Chapter 6. Your rights and responsibilities

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.
- To have full, candid discussions regarding appropriate or medically necessary diagnostic and treatment options with your physician, regardless of cost or benefit coverage.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's member rights and responsibilities.

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

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

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

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

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

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

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

Chapter 6. Your rights and responsibilities

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Livanta BFCC-QIO Program, 9090 Junction Drive, Suite 10, Annapolis Junction, MD 20701; telephone number: **1-866-815-5440**; TTY/TDD: **1-866-868-2289**.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our Plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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

Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

Chapter 6. Your rights and responsibilities

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

Section 1.9 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the last page of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: <http://www.medicare.gov/Pubs/pdf/11534.pdf>.)
 - Or, you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the last page of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our Plan, or separate prescription drug coverage, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the last page of this booklet).

Chapter 6. Your rights and responsibilities

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our Plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our Plan with any other health benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our Plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our Plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a Copayment (a fixed amount) or Coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
 - If you get any medical services that are not covered by our Plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it’s important to tell us right away. Call Member Services (phone numbers are printed on the last page of this booklet).
 - **If you move *outside* of our Plan service area, you cannot remain a member of our Plan.** (Chapter 1 tells about our service area.) We can help you figure out

Chapter 6. Your rights and responsibilities

whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our Plan.
 - Phone numbers and calling hours for Member Services are printed on the last page of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.
- Provide information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that you agreed upon with your physician.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

CHAPTER 7

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

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

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

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

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**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****BACKGROUND****SECTION 1 Introduction****Section 1.1 What to do if you have a problem or concern**

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

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

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you

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

want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

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

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the last page of this booklet).
- To **get free help from an independent organization** that is not connected with our Plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

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

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the last page of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at **HorizonBlue.com/shbp**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3	Which section of this chapter gives the details for your situation?
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There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

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

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****SECTION 5 Your medical care: How to ask for a coverage
decision or make an appeal**

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our Plan.
2. Our Plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our Plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
 - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
 - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

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

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

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

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

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

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*

Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination**.”

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

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

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

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

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

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

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

- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

Deadlines for a “fast coverage decision”

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

Deadlines for a “standard coverage decision”

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information

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

about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

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

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** Standard pre-service appeals must be submitted in writing. You may ask for a standard payment appeal by calling us at the phone number shown in Chapter 2, Section 1, (*How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*).

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “**reconsideration.**”

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

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

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

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

Legal Terms

A “fast appeal” is also called an
“expedited reconsideration.”

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

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

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

Deadlines for a “fast” appeal

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

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

- If you had a fast appeal to our Plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

- If you had a standard appeal to our Plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

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

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

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

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

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?
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If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

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

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

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

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

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

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

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

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

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

Section 6.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice,

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

ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the last page of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

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

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

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

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

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the last page of this booklet) or **1-800 MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

Section 6.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

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Act quickly:

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

Ask for a “fast review”:

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

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

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

What happens during this review?

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

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Legal Terms

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

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

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or Copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

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

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

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

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

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can

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choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

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

Legal Terms

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

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

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

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

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

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

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

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

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

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

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

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

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

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

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

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

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

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

Section 7.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

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

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

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

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

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

Legal Terms

In telling you what you can do, the written notice is telling how you can request a “**fast-track appeal**.” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

The written notice is called the “**Notice of Medicare Non-Coverage**.” To get a sample copy, call Member Services (phone numbers are printed on the last page of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

1. **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.

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(coverage decisions, appeals, complaints)**

- The written notice also tells what you can do if you want to ask our Plan to change this decision about when to end your care, and keep covering it for a longer period of time.

2. You must sign the written notice to show that you received it.

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

Section 7.3	Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the last page of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

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(coverage decisions, appeals, complaints)**

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

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

Legal Terms

This notice of explanation is called the “**Detailed Explanation of Non-Coverage.**”

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.***What happens if the reviewers say yes to your appeal?***

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

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

What happens if the reviewers say no to your appeal?

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

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

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

Section 7.4	Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

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

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

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

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

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when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

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

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

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

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

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

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

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our Plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are

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coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal**, it means they agree with the decision our Plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge’s decision.

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- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the administrative appeals process.

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

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

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

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

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

If you have any of these kinds of problems, you can “make a complaint”

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

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

Complaint	Example
<p>Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

Section 9.2 The formal name for “making a complaint” is “filing a grievance”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.

For Medical Care and Services:

You can reach us at **1-800-414-7427**

Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET.

TTY/TDD users may call 711

Hours of Operation: 24 hours a day, 7 days a week

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **For complaints about Medical Care and Services:**
 - We have 30 calendar days from the date we receive your grievance (complaint) to resolve the complaint and notify you of our decision.
 - We may use a 14-day extension if we require further research into the issue and it is in your best interest to continue to research.
 - We will notify you by letter if we take a 14-day extension
 - **If making an oral complaint:** Have the following prepared for the representative:
 - *Your name*
 - *Your address*
 - *Your Member ID Number*
 - *A description of your complaint/grievance*
 - **If you are sending your complaint in writing:** Include the following in your letter:
 - *Your name*

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

- *Your address*
- *Your Member ID Number*
- *A description of your complaint/grievance*
- *Send it to:*
Horizon Medicare Advantage
3 Penn Plaza East, PP-12L
Newark, NJ 07105-2200

You may file an expedited grievance (complaint) if:

- We deny your request for a fast (expedited) decision about your request for a service.
- We deny your request for a fast (expedited) appeal for a service.
- We need to take extra days (take an extension) to decide on your request for a service.
- We need to take extra days (take an extension) to consider your appeal for a service.

If we deny your request to a fast (expedited) decision or if we need to take extra days (take an extension) to resolve your grievance, you will receive a letter that explains you may file an expedited grievance. We will respond to your expedited grievance within 24 hours with our decision.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint”.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms
What this section calls a “fast complaint” is also called an “expedited grievance.”

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

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

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our Plan directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our Plan

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our Plan, you must continue to get your medical care through our Plan until your membership ends.

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

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

You may end your membership in our Plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can 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. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

Chapter 8. Ending your membership in the plan

- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited
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You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of our Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid (New Jersey Department of Human Services).
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

Chapter 8. Ending your membership in the plan

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
 - Original Medicare *with* a separate Medicare prescription drug plan;
 - – *Or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

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

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the last page of this booklet).
- You can contact the Division of Pensions and Benefits Office at **1-609-292-7524**.
- You can find the information in the *Medicare & You 2018* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

Section 3.1 Usually, you end your membership by enrolling in another plan

We hope to keep you as a member next year but if you want to change plans please contact the Division of Pensions and Benefits Office at **1-609-292-7524** to cancel your current coverage.

Chapter 8. Ending your membership in the plan

The Division of Pensions and Benefits Office will advise you of other SHBP options. Otherwise you can follow the steps below:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the last page of this booklet).
- --or-- You can contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

If you would like to switch from our Plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. You will automatically be disenrolled from Horizon Medicare Advantage NJ DIRECT15 (PPO) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Horizon Medicare Advantage NJ DIRECT15 (PPO) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the last page of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Horizon Medicare Advantage NJ DIRECT15 (PPO) when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our Plan
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If you leave our Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our Plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Our Plan must end your membership in the plan in certain situations

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

Our Plan must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our Plan's area. (Phone numbers for Member Services are printed on the last page of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our Plan and that information affects your eligibility for our Plan. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our Plan. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our Plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Chapter 8. Ending your membership in the plan

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the last page of this booklet).

Section 5.2	We cannot ask you to leave our Plan for any reason related to your health
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Horizon Medicare Advantage NJ DIRECT15 (PPO) is not allowed to ask you to leave our Plan for any reason related to your health.

What should you do if this happens?

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

Section 5.3	You have the right to make a complaint if we end your membership in our Plan
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If we end your membership in our Plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

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Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, creed, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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 and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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, HIC, 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 coverage during unforeseen circumstances

Provision of benefits and services under our Plan could be delayed or rendered impracticable by circumstances not reasonably within the control of HIC, network providers or network facilities, such as; an epidemic; a terrorist event; a major disaster; the complete or partial destruction of facilities because of war; riot or civil insurrection; the disability of a significant number of providers; or similar causes. In the event, neither HIC, nor any provider shall have any liability or obligation for delay or failure to provide such services provided they have, in good faith, used their best efforts to render services to the extent practicable: 1) according to their best judgment; and 2) within the limitation of the facilities and personnel then available. Coverage during a federal disaster or other public health emergency declaration will be provided pursuant to CMS requirements.

SECTION 5 Disclaimer regarding out-of-network/non-contracted providers

Out-of-network/non-contracted providers are under no obligation to treat members of our Plan, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

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

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our Plan you only have to pay our Plan's cost-sharing amounts when you get **Medicare eligible** services covered by our Plan. For Medicare eligible services, we do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay. Please note there are some plan covered services that are not Medicare eligible and are excluded from this protection. When you receive services that are not Medicare eligible you may be balanced billed. Please see the back of the Medical Benefits Chart in Chapter 4 for these services that are not Medicare eligible but are covered by our Plan.

Benefit Period The way that our Plan measures your use of skilled nursing facility (SNF) services. A Benefit Period begins the day you go into a skilled nursing facility. The Benefit Period ends when you haven't received any skilled care in a SNF for 90 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. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services: after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Chapter 10. Definitions of important words

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

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, or hospital outpatient visit. A Copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription.

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

Covered Services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

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

Deductible – The amount you must pay for health care before our Plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

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

Chapter 10. Definitions of important words

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

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

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

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

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our Plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

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

Maximum Out-of-Pocket Amount – The most you will pay in a calendar year for covered services from network (preferred) and/or out-of-network (non-preferred) providers. Under our Plan, there are two different limits on what you have to pay out-of-pocket for covered medical services. See Chapter 4, Section 1.4 for information about your maximum out-of-pocket amounts.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Chapter 10. Definitions of important words

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare: a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2018.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our Plan, must cover all of the services that are covered by Medicare Part A and B.

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

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).

Chapter 10. Definitions of important words

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our Plan or another Blue Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we or another Blue Plan has not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Chapter 10. Definitions of important words

Part A – Medicare Part A (Hospital Insurance) helps cover Inpatient care in hospitals, Inpatient care in a skilled nursing facility (not custodial or long-term care), Hospice care services, Home health care services, and Inpatient care in a religious nonmedical health care institution.

Part B – Medicare Part B (Medical Insurance) helps cover medically necessary doctors' services, outpatient care, home health services, durable medical equipment, and other medical services. Part B also covers many preventive services.

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

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

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

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our Plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Chapter 10. Definitions of important words

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

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

Special Enrollment Period – A set time when members can change their health or drugs 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.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Our Plan's Member Services

Method	Member Services – Contact Information
CALL	<p>1-800-414-7427</p> <p>Calls to this number are free. Hours of Operation: Monday – Friday, between 8:00 a.m. - 6:00 p.m., ET.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY/TDD	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Hours of Operation: 24 hours a day, 7 days a week.</p>
WRITE	<p>Horizon Insurance Company Member Services P. O. Box 820 Newark, NJ 07101-0820</p>
WEBSITE	HorizonBlue.com/shbp

State Health Insurance Assistance Program (New Jersey SHIP)

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-792-8820
WRITE	<p>State Health Insurance Assistance Program P.O. Box 807 Quakerbridge Plaza Hamilton, NJ 08690-0807</p>
WEBSITE	www.state.nj.us/humanservices/doas/services/ship/

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Our Plan's Member Services

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