

**Select
Health**

Select Health Medicare | 2026

Evidence of Coverage

Select Health Medicare

No Rx (HMO) 016

This page intentionally left blank

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of *Select Health Medicare NoRx (HMO)*

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

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

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

For questions about this document, call Member Services at 1-855-442-9900. (TTY users call 711). Hours are:

- **October 1 to March 31:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.
- **April 1 to September 30:** Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. **This call is free.**

Outside of these hours of operation, please leave a message and your call will be returned within one business day.

This plan, *Select Health Medicare NoRx*, is offered by Select Health. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Select Health. When it says “plan” or “our plan,” it means *Select Health Medicare NoRx*.)

This document is available for free in Spanish. This document may be available in an alternate format, free of charge. To request an alternate format, call Member Services at **1-855-442-9900** (toll-free). TTY users call **711**.

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

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

Notice of Availability

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats by contacting Select Health Medicare at 1-855-442-9900 (TTY: 711).

English ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-855-442-9900 (TTY: 711)** or speak to your provider.

Español ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **1-855-442-9900 (TTY: 711)** o hable con su proveedor.

台語 注意：如果您說[台語]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 **1-855-442-9900 (TTY: 711)** 或與您的提供者討論。

Tagalog PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **1-855-442-9900 (TTY: 711)** o makipag-usap sa iyong provider.

Français ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **1-855-442-9900 (TTY: 711)** ou parlez à votre fournisseur.

Việt LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số **1-855-442-9900 (TTY: 711)** hoặc trao đổi với người cung cấp dịch vụ của bạn.

Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie **1-855-442-9900 (TTY: 711)** an oder sprechen Sie mit Ihrem Provider.

한국어 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **1-855-442-9900 (TTY: 711)** 번으로 전화하거나 서비스 제공업체에 문의하십시오.

РУССКИЙ ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **1-855-442-9900 (TTY: 711)** или обратитесь к своему поставщику услуг

كما . إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية: العربية تبيه. اتصل. تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا أو تحدث إلى مقدم الخدمة **1-855-442-9900 (TTY:711)** على الرقم

हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके दलए विशुल्क भाषा सहायता सेवाएँ उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के दलए उपयुक्त सहायक साधन और सेवाएँ भी दनि: शुल्क उपलब्ध हैं। **1-855-442-9900 (TTY: 711)** पर कॉल करें या अपने प्रदाता से बात करें।

Italiano ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il **1-855-442-9900 (TTY: 711)** o parla con il tuo fornitore.

Português do Brasil ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para **1-855-442-9900 (TTY: 711)** ou fale com seu provedor.

Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm akse sib yo disponib gratis tou. Rele nan **1-855-442-9900 (TTY: 711)** oswa pale avèk founisè w la.

Polski UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **1-855-442-9900 (TTY: 711)** lub porozmawiaj ze swoim dostawcą.

日本語 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。**1-855-442-9900 (TTY: 711)** までお電話ください。または、ご利用の事業者にご相談ください

Table of Contents**Table of Contents**

CHAPTER 1: Get started as a member	4
SECTION 1 You're a member of Select Health Medicare NoRx	4
SECTION 2 Plan eligibility requirements	4
SECTION 3 Important membership material.....	5
SECTION 4 Summary of Important Costs for 2026	7
SECTION 5 Keep our plan membership record up to date.....	8
SECTION 6 How other insurance works with our plan	9
 CHAPTER 2: Phone numbers and resources	 11
SECTION 1 <i>Select Health Medicare NoRx</i> contacts.....	11
SECTION 2 Get help from Medicare.....	14
SECTION 3 State Health Insurance Assistance Program (SHIP).....	15
SECTION 4 Quality Improvement Organization (QIO)	16
SECTION 5 Social Security	17
SECTION 6 Medicaid	18
SECTION 7 Railroad Retirement Board (RRB).....	19
SECTION 8 If you have group insurance or other health insurance from an employer	19
 CHAPTER 3: Using our plan for your medical services	 21
SECTION 1 How to get medical care as a member of our plan	21
SECTION 2 Use providers in our plan's network to get medical care	22
SECTION 3 How to get services in an emergency, disaster, or urgent need for care	27
SECTION 4 What if you're billed directly for the full cost of covered services?	29
SECTION 5 Medical services in a clinical research study.....	30
SECTION 6 Rules for getting care in a religious non-medical health care institution.....	31
SECTION 7 Rules for ownership of durable medical equipment	32
 CHAPTER 4: Medical Benefits Chart (what's covered and what you pay).....	 35
SECTION 1 Understanding your out-of-pocket costs for covered services	35
SECTION 2 The Medical Benefits Chart shows your medical benefits and costs	36

Table of Contents

SECTION 3	Services that aren't covered by our plan (exclusions).....	80
CHAPTER 5:	Asking us to pay our share of a bill for covered medical services	87
SECTION 1	Situations when you should ask us to pay our share for covered services	87
SECTION 2	How to ask us to pay you back or pay a bill you got	89
SECTION 3	We'll consider your request for payment and say yes or no.....	90
CHAPTER 6:	Your rights and responsibilities	91
SECTION 1	Our plan must honor your rights and cultural sensitivities.....	91
SECTION 2	Your responsibilities as a member of our plan	101
CHAPTER 7:	If you have a problem or complaint (coverage decisions, appeals, complaints)	103
SECTION 1	What to do if you have a problem or concern	103
SECTION 2	Where to get more information and personalized help	103
SECTION 3	Which process to use for your problem.....	104
SECTION 4	A guide to coverage decisions and appeals	104
SECTION 5	Medical care: How to ask for a coverage decision or make an appeal	107
SECTION 6	How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon	115
SECTION 7	How to ask us to keep covering certain medical services if you think your coverage is ending too soon	119
SECTION 8	Taking your appeal to Levels 3, 4 and 5	123
SECTION 9	How to make a complaint about quality of care, waiting times, customer service, or other concerns.....	125
CHAPTER 8:	Ending membership in our plan.....	129
SECTION 1	Ending your membership in our plan.....	129
SECTION 2	When can you end your membership in our plan?	129
SECTION 3	How to end your membership in our plan	131
SECTION 4	Until your membership ends, you must keep getting your medical items and services through our plan	132
SECTION 5	<i>Select Health Medicare NoRx</i> must end our plan membership in certain situations	132
CHAPTER 9:	Legal notices	134

Table of Contents

SECTION 1	Notice about governing law.....	134
SECTION 2	Notice about nondiscrimination	134
SECTION 3	Notice about Medicare Secondary Payer subrogation rights	134
CHAPTER 10: Definitions.....		136

CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Select Health Medicare NoRx

Section 1.1 You're enrolled in *Select Health Medicare NoRx*, which is a Medicare HMO

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

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

Section 1.2 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months you're enrolled in *Select Health Medicare NoRx* between January 1, 2026, and December 31, 2026.

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

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

Chapter 1 Get started as a member

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

Section 2.2 Plan service area for *Select Health Medicare NoRx*

Select Health Medicare NoRx is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Utah: Davis, Salt Lake, Utah and Weber

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at **855-442-9900** (TTY users call **711**) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

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



Section 2.3 U.S. citizen or lawful presence

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

SECTION 3 Important membership material

Section 3.1 Our plan membership card

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

 Select Health MEDICARE NETWORK Member Name ID: 800000000 Member Services: 855-442-9900 (TTY: 711) Find a Doctor: 800-515-2220 selecthealth.org/medicare P.O. Box 30196 Salt Lake City, UT 84130-0196	Select Health Medicare (Plan Name) (Plan Type) (Plan ID) In-Network Medical Benefits Medical Deductible: \$xxx Preventive Care: \$xx Primary Care: \$xx Specialty Care: \$xx Virtual Urgent Care: \$xx Urgent Care Clinic: \$xx Emergency Room: \$xxx Pharmacy Benefits RX Deductible: \$xxx Tier 1: \$xx Tier 2: \$xx Tier 3: \$xx Tier 4: \$xx Tier 5: \$xx RX BIN: 012345 RX PCN: 0123 RX GRP ID: U10000xx 
---	---

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

If our plan membership card is damaged, lost, or stolen, call Member Services at **855-442-9900** (TTY users call **711**) right away and we'll send you a new card.

Section 3.2 Provider Directory

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

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

Get the most recent list of providers and suppliers on our website at selecthealth.org/medicare/find-care/provide-directories.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at **855-442-9900** (TTY users call **711**). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2026

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out-of-pocket for covered services. (Go to Chapter 4 Section 1.2 for details.)	\$6,700
Primary care office visits	\$0 per visit
Specialist office visits	\$50 Copay per visit
Inpatient hospital stays	\$500 Copay per day for days 1-5. \$0 Copay per day for days 6-90. Additional days: you pay \$0 per day for each additional day.

Your costs may include the following:

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

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for *Select Health Medicare NoRx*.

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

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums.

As a member of *Select Health Medicare NoRx* you receive up to a \$100 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

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

Section 4.3 Our monthly plan premium won't change during the year

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

SECTION 5 Keep our plan membership record up to date

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

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

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

- Changes to your name, address, or phone number
- Changes to your Primary Care Provider

Chapter 1 Get started as a member

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

If any of this information changes, let us know by calling Member Services at **855-442-9900** (TTY users call **711**).

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

SECTION 6 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at **855-442-9900** (TTY users call **711**). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by

Chapter 1 Get started as a member

your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

- If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
- If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2: Phone numbers and resources

SECTION 1 *Select Health Medicare NoRx* contacts

For help with claims, billing, or member card questions, call or write to *Select Health Medicare NoRx* Member Services **855-442-9900** (TTY users call **711**). We'll be happy to help you.

Member Services	Contact Information
Call	(855) 442-9900 Calls to this number are free. October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m., April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. (Outside of these hours of operation, please leave a message and your call will be returned within one business day.) Member Services 855-442-9900 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. See above for days and hours of operation.
Fax	801-442-6580
Write	Select Health Medicare Attn: Member Services PO Box 30196 Salt Lake City, UT 84130
Website	selecthealth.org/medicare

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

Chapter 2 Phone numbers and resources

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

Coverage Decisions and Appeals for Medical Care Contact Information											
Call	<p>(855) 442-9900</p> <p>Calls to this number are free.</p> <p>October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.</p> <p>April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.</p> <p>(Outside of these hours of operation, please leave a message and your call will be returned within one business day.)</p>										
TTY	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.</p> <p>Calls to this number are free. See above for days and hours of operation.</p>										
Fax	<p>801-442-6580 Coverage Decisions</p> <p>801-442-0762 Appeals</p>										
Write	<table border="0"> <thead> <tr> <th>Coverage Decisions</th> <th>Appeals</th> </tr> </thead> <tbody> <tr> <td>Select Health Medicare</td> <td>Select Health Medicare</td> </tr> <tr> <td>Attn: Member Services</td> <td>Attn: Appeals and Grievances</td> </tr> <tr> <td>PO Box 30196</td> <td>PO Box 30196</td> </tr> <tr> <td>Salt Lake City, UT 84130</td> <td>Salt Lake City, UT 84130</td> </tr> </tbody> </table>	Coverage Decisions	Appeals	Select Health Medicare	Select Health Medicare	Attn: Member Services	Attn: Appeals and Grievances	PO Box 30196	PO Box 30196	Salt Lake City, UT 84130	Salt Lake City, UT 84130
Coverage Decisions	Appeals										
Select Health Medicare	Select Health Medicare										
Attn: Member Services	Attn: Appeals and Grievances										
PO Box 30196	PO Box 30196										
Salt Lake City, UT 84130	Salt Lake City, UT 84130										
Website	selecthealth.org/medicare										

How to make a complaint about your medical care

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

Complaints about Medical Care Contact Information	
Call	(855) 442-9900 Calls to this number are free. October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m., April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. (Outside of these hours of operation, please leave a message and your call will be returned within one business day.)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. See above for days and hours of operation.
Fax	801-442-0762
Write	Select Health Medicare Attn: Appeals and Grievances PO Box 30196 Salt Lake City, UT 84130
Medicare website	To submit a complaint about <i>Select Health Medicare NoRx</i> directly to Medicare, go to www.Medicare.gov/my/medicare-complaint .

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

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

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

Payment Requests Contact Information	
Call	(855) 442-9900 Calls to this number are free. October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m., April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. (Outside of these hours of operation, please leave a message and your call will be returned within one business day.)
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. See above for days and hours of operation.
Fax	801-442-6580
Write	Select Health Medicare Attn: Member Services PO Box 30196 Salt Lake City, UT 84130
Website	selecthealth.org/medicare

SECTION 2 Get help from Medicare

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

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

Medicare Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.

Medicare Contact Information	
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov <ul style="list-style-type: none">• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.• Find Medicare-participating doctors or other health care providers and suppliers.• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).• Get Medicare appeals information and forms.• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.• Look up helpful websites and phone numbers. <p>You can also visit www.Medicare.gov to tell Medicare about any complaints you have about <i>Select Health Medicare NoRx</i>.</p> <p>To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</p>

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to

your Medicare questions. In *Utah*, the SHIP is called Senior Health Insurance Information Program.

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

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

Senior Health Insurance Information Program (Utah's SHIP) Contact Information	
Call	800-541-7735
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Division of Aging and Adult Services Utah Department of Human Services 195 North 1950 West Salt Lake City, UT 84116
Website	daas.utah.gov/seniors

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Acentra in any of these situations:

Chapter 2 Phone numbers and resources

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

Acentra: (Utah's Quality Improvement Organization) Contact Information

Call	888-317-0891 Calls to this number are free. Helpline hours of operation: weekdays 9:00 a.m. to 5:00 p.m., weekends and holidays: 11:00 a.m. to 3:00 p.m. Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time.
TTY	855-843-4776 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Acentra 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
Website	www.acentraqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
-------------	--

Social Security Contact Information

<p>TTY</p>	<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 8 am to 7 pm, Monday through Friday.</p>
<p>Website</p>	<p>www.SSA.gov</p>

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact the Utah Department of Health.

Utah Medicaid Program Contact Information

<p>Call</p>	<p>866-608-9422</p> <p>Medicaid Customer Service Hours of Operations: Monday through Friday, 8:00 a.m. – 5:00 p.m. Closed on all state and federal holidays.</p>
<p>TTY</p>	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.</p>

Utah Medicaid Program Contact Information

Write	Utah Department of Health Division of Medicaid and Health Financing PO Box 143106 Salt Lake City, UT 84114
Website	medicaid.utah.gov

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) Contact Information

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union

Chapter 2 Phone numbers and resources

benefits administrator or Member Services at **855-442-9900** (TTY users call **711**) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

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

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

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

Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, *Select Health Medicare NoRx* must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

Select Health Medicare NoRx will generally cover your medical care as long as:

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

- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. *Here are 3 exceptions:*
 - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. However, you must get authorization from our plan prior to seeking care. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

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

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

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

Your Primary Care Provider (PCP) is the health care provider that you see to receive the care that you need to keep you healthy. He or she is usually the physician that you see most frequently and will diagnose and treat most common medical problems. Your PCP will help you coordinate all of your medical care and will communicate with specialist physicians and other health care providers to address your medical needs. As an in-network provider, your PCP will request prior authorization when required.

Your Primary Care Provider may be any of the following provider types:

- Family Medicine
- Internal Medicine
- Geriatrician

Services your PCP will usually provide include:

- Welcome to Medicare visit
- Annual Routine Physical and Annual Wellness Visit
- Immunizations
- Preventive Care Services (see preventive care benefit information)
- Chronic Condition management (such as diabetes, hypertension, obesity treatments)
- Urgent Care needs

How to choose a PCP?

In-network PCPs can be found in the *Provider Directory*. If you would like us to help you select a PCP, please call Member Services (numbers are printed on the back cover of this booklet). If you already have a PCP when you enroll in Select Health Veteran Advantage, make sure that he or she is a network provider listed in the *Provider Directory*. You are responsible to confirm that your provider is contracted with our Plan. For the most updated *Provider Directory* information, please call Member Services or visit our website at selecthealth.org/medicare. If you do not choose a PCP, we will assign one to you. You can change your PCP at any time by contacting us as outlined below.

Member Advocates can also help you choose or change your Primary Care Physician. Member Advocates act as an intermediary for you and in-network providers to achieve effective communication, better care outcomes, and your complete satisfaction. They specialize in helping you find the right doctor for your needs. They can assist you in scheduling an appointment, as well as help you finding the closest facility or doctor with the soonest available appointment. You can reach a Member Advocate by calling toll-free **800-515-2220** (TTY users should call **711**) weekdays from 7:00 a.m. to 8:00 p.m. and Saturdays from 9:00 a.m. to 2:00 p.m.

How to change your PCP

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

If you need to change your PCP, simply call Member Services and notify us of the change. The change will take effect on the first day of the month following the date of the request, immediately upon receipt of request, etc.

Section 2.2 How to get care from specialists and other network providers

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

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

Although your plan does not require referrals in order to receive care from a specialist, it is generally good practice to coordinate care through your PCP and allow them to help determine if specialty care is needed. PCPs are able to treat a wide range of problems and can often do so at a lower cost to you than seeing a specialist.

In-network providers are responsible to obtain prior authorization for services when required. As long as you use in-network providers you will not be required to request prior authorization. If you use out-of-network providers, you are responsible to seek prior authorization for services when required. The plan makes the decision on whether the service will be covered. Refer to Chapter 4, Section 2.1 for information about which services require prior authorization.

Finding a Select Health Medicare Specialist Provider

In-network Specialist Providers (SCP) can be found in the *Provider Directory*. You can also go to selecthealth.org/medicare, click on “Find a Doctor,” and choose the type of specialist that is needed from the list to find the most current list of participating providers.

Member Advocates can also help you find a SCP to fit your needs. They specialize in helping you find the right doctor for your needs. They can assist you in scheduling an appointment, as well as help you finding the closest facility or doctor with the soonest available appointment. You can reach a Member Advocate by calling toll-free **800-515-2220** (TTY users should call **711**) weekdays from 7:00 a.m. to 8:00 p.m. and Saturdays from 9:00 a.m. to 2:00 p.m.

If you need a Select Health Medicare *Provider Directory* or want help finding a provider, please call Member Services (phone numbers for Member Services are printed on the back cover of this booklet.). Always make sure your provider is in the network before you get care.

Finding a Select Health Medicare Dental Provider

To find a provider for your dental plan, see the Select Health Medicare Dental *Provider Directory*. You can also go to selecthealth.org/medicare, click on “Find a Doctor,” and

choose Dental Advantage from the list to find the most current list of participating dental providers.

If you need a Select Health Medicare Dental *Provider Directory* or want help finding a provider, please call Member Services (phone numbers for Member Services are printed on the back cover of this booklet.). Always make sure your provider is in the network before you get care.

Finding an EyeMed Provider or Vision Care® Hardware Retailer

The EyeMed Access network is for routine eye exams, refractions and vision hardware. You may choose to get vision hardware (contacts, frames, & lenses) from any EyeMed Vision provider in the Access Network.

To find a provider for eye exams, or a retailer for your vision hardware benefit, or get assistance with questions about your benefit, call EyeMed Vision Member Services at **844-872-8868** (TTY users should call **711**). Hours are:

- **April 1 to September 30:** Monday - Friday 6:00 a.m. to 12:00 a.m., Saturday 6:00 a.m. to 9:00 p.m., and Sunday 9:00 a.m. to 6:00 p.m.
- **October 1 to March 31:** Monday - Saturday 6:00 a.m. to 12:00 a.m., Sunday 6:00 a.m. to 12:00 a.m.

You can also go to selecthealth.org/medicare, and log into your member account. Once you log in you will land on the Dashboard page where you will find the EyeMed banner. From there you can choose to access your EyeMed account to get to the EyeMed member portal. Use the search tool to find a provider or retailer near you in the Access network.

Finding a Hearing Aid Provider with Intermountain Health Audiology

Hearing aids and exams to fit hearing aids are not covered unless you use an approved audiologist in an Intermountain Health Audiology. To find a provider for your hearing aid benefit see the *Provider Directory*, or you can call Member Services (phone numbers are printed on the back cover of this booklet).

If you need a *Provider Directory*, or want help finding a provider, please call Member Services (phone numbers are printed on the back cover of this booklet). Always make sure your provider is in the network before you get care.

Note: For Diagnostic hearing and balance evaluations, and routine hearing exams, you will need to use a provider on the Select Health Medicare network. To find an audiologist for hearing and balance evaluations or other hearing care, see the *Provider Directory*, or call Member Services (phone numbers are printed on the back cover of this booklet).

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization is needed.
- If you find out your doctor or specialist is leaving our plan, call Member Services at **1-855-442-9900** (TTY users call **711**) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

For assistance call Member Services (phone numbers for Member Services are printed on the back cover of this booklet). Always make sure your provider is in the network before you get care.

Section 2.3 How to get care from out-of-network providers

In general, care is not covered from providers that are not part of the Select Health Medicare network. If you need covered services aren't available through a contracted provider, then we will arrange for you to receive care from a provider outside the network. Call Member Services

for help arranging for services from out-of-network providers. Prior Authorization will be required to ensure services are covered at in-network cost-sharing.

Covered services may be received from out-of-network providers for emergency or out of area urgently needed services. In addition, we will cover dialysis services for members with ESRD who have traveled outside our plan's service area and aren't able to access contracted ESRD providers.

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact Member Services at **1-855-442-9900** (phone numbers are printed on the back cover of this booklet).

Covered services in a medical emergency

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

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

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

If you are seeking care after hours, or you are unable to find an in-network provider, you can go to an Intermountain InstaCare® or other in-network urgent care facility or contact our Member Advocates. They specialize in helping you find the right doctor for your needs. They can assist you in scheduling an appointment, including urgent conditions, as well as help you find the closest facility or doctor with the soonest available appointment. You can reach a Member Advocate by calling toll-free **800-515-2220** (TTY users should call **711**) weekdays from 7:00 a.m. to 8:00 p.m. and Saturdays from 9:00 a.m. to 2:00 p.m.

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgent care services outside the United States. You pay the same copay amount while traveling that you would pay if you use in-network providers. See the benefit chart in Chapter 4 for information on the copays you pay for urgent and emergency care. If you are asked to pay up front for services while traveling outside the United States, and need to seek reimbursement from us, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services or Part B drugs*) for information on how to ask us to reimburse you.

Section 3.3 Get care during a disaster

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

Visit [ready.gov](https://www.ready.gov) for information on how to get needed care during a disaster.

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

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

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

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

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

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will count toward an 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 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a

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

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

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

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

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

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

You are covered for an unlimited number of medically-necessary inpatient hospital acute care days. Refer to Chapter 4, Section 2.1, Inpatient Hospital Benefits for additional information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of *Select Health Medicare NoRx*, however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at **855-442-9900** (TTY users call **711**) for more information.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, *Select Health Medicare NoRx* will cover:

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

If you leave *Select Health Medicare NoRx* or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides

Chapter 3 Using our plan for your medical services

the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

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

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

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

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

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

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

Section 1.2 What's the most you'll pay for covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$6,700.**

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$6,700, you won't have to pay any out-of-pocket costs for the rest of the year for in-network

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

covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at **855-442-9900** (TTY users call **711**).

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

The Medical Benefits Chart on the next pages lists the services *Select Health Medicare NoRx* covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

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

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. These services not listed in the Medical Benefits Chart also require prior authorization:
 - Abortion procedures
 - Acupuncture services
 - All admissions to facilities, including (but not limited to) rehabilitation, residential treatment, transitional care, skilled nursing facilities and all hospitalizations, partial hospitalizations, or observations that are not for urgent or emergency conditions
 - Certain antigen receptor T-Cell therapy
 - Certain ambulance services
 - Non-emergency transportation by ambulance
 - Certain cancer treatments
 - Ambulatory/Outpatient Surgeries not being performed in an Ambulatory Surgical Center
 - Bariatric or weight loss procedures
 - Chiropractic services exceeding 10 visits
 - Cochlear and auditory brainstem implants

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

- Continuous glucose monitors
- Potentially cosmetic procedures, including (but not limited to):
 - Breast procedures (reductions, enlargements, tattooing and/or reconstruction)
 - Chest wall procedures
 - Eye procedures
 - Facial surgeries
 - Liposuction and panniculectomy
 - Plastic/reconstructive surgery procedures
 - Scar revisions
 - Vein procedures
- Dental services and oral appliances covered under Original Medicare, including any services related to the teeth or structures directly supporting the teeth
- Certain Durable Medical Equipment (DME), prosthetics/orthotics, medical supplies, and implants, including (but not limited to):
 - All DME items, prosthetics/orthotics, and medical supplies with purchase price greater than \$1,500
 - External defibrillators
 - High frequency chest compression vest
 - INR monitors
 - Insulin pumps
 - Medication and infusion pumps
 - Negative pressure wound therapy
 - Speech devices
 - Vision aids
- Experimental or investigational medical and surgical procedures, equipment, and medications, except as provided under a Medicare-approved clinical trial (for more information on clinical trials see Chapter 3 section 5).
- Certain foot surgery
- Certain genetic testing
- Gender affirmation surgery
- Certain home health services

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

- Hyperbaric oxygen therapy
- Certain genitourinary procedures (ex: hysterectomies)
- Infertility services
- Certain injectable drugs and specialty medications
- Joint procedures including (but not limited to):
 - Arthroscopies
 - Autologous chondrocyte implantation of the knee
 - Joint replacements
- Certain laboratory tests
- Certain Neuropsychological testing, psychological services and biofeedback
- Neuro-surgery spine procedures
- Obstructive Sleep Apnea procedures
- Oral/Maxillofacial procedures
- Outpatient diagnostic tests and procedures (in a provider office or outpatient facility), including but not limited to
 - Certain advanced bronchoscopy, endoscopy, and colonography procedures
 - Certain advanced cardiac imaging
 - Certain advanced imaging (MRI, MRA and CT scans)
 - Certain advanced radiation and proton beam treatments
 - Certain Positron Emission Tomography (PET) scans
- Certain outpatient hospital, office based or facility services and procedures including (but not limited to) intensive outpatient programs for medical and behavioral health services
- Pain management
- Certain prescription drugs, see chapter 5 & 6 for more information
- Rehabilitation therapy services
- Robotic procedures
- Sexual dysfunction treatments
- Certain spinal surgeries
- Stereotactic surgery and radiosurgery

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

- Stimulators (external or implantable for neuro, bone growth, and pain, except TENS units)
- Certain Surgical/Procedures in a physician's office
- Certain cardiac procedures, including but not limited to transcatheter valve replacements and other advanced percutaneous cardiac procedures
- Transplants
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.


Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.




This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart




Covered Service	What you pay
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>
<p>Acupuncture for chronic low back pain*</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. <p>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act),</p>	<p>You pay a \$50 copayment for each Medicare-covered acupuncture visit for chronic low back pain.</p>

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


Covered Service	What you pay
<p>and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a master’s or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p>*Prior Authorization may be required for Medicare-covered acupuncture services. Refer to Chapter 4, Section 2.1 above for additional information. In-network providers are responsible to obtain prior authorization.</p>	
<p>Ambulance services*</p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they’re furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by our plan. If the covered ambulance services aren’t for an emergency situation, it should be documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</p> <p>*Prior Authorization is required for non-emergency transportation by ambulance. You are responsible to obtain prior authorization for this service.</p>	<p>You pay a \$250 copayment for Medicare-covered ambulance services (each way).</p> <p>You pay a \$250 copayment for authorized non-emergency transportation by ambulance (each way).</p>
<p> Annual wellness visit</p>	<p>There is no coinsurance, copayment, or deductible</p>

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

Covered Service	What you pay
<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 every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services*</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.</p> <p>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> <p>*Prior authorization is required. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$0 copayment for each Medicare-covered cardiac rehabilitation visit.</p>

Covered Service	What you pay
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease screening tests</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • <i>We cover only</i> Manual manipulation of the spine to correct subluxation <p>*Prior Authorization is required for chiropractic services exceeding 10 visits. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$15 copayment for each Medicare-covered chiropractic visit.</p>
<p>Chronic pain management and treatment services</p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.</p>	<p>Cost sharing for this service will vary depending on individual services provided under the course of treatment.</p>

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




Covered Service	What you pay
	You pay 20% coinsurance for Medicare-covered chronic pain management and treatment services.
 Colorectal cancer screening The following screening tests are covered: <ul style="list-style-type: none"> • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. 	There is no coinsurance, copayment, or deductible for Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Covered Service	What you pay
<ul style="list-style-type: none"> • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. 	
<p>Dental services</p> <p>This benefit is administered by Select Health Medicare Dental. Services are only covered when you use providers that are in the Select Health Medicare Dental network. (For information on how to find a Select Health Medicare Dental network provider see chapter 3, section 2.2.)</p> <p>Comprehensive dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren’t covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.</p> <p>In addition, we cover: preventive, basic, and major dental services as outlined here:</p> <p>There is an annual maximum plan payment of \$1,500 that applies for preventive, basic, and major services..</p> <p><u>Preventive dental services</u></p>	<p>You pay a \$0 copayment for covered preventive dental services.</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> • Two routine dental exams per year • Two dental cleanings per year • Two sets of bitewing x-rays per year • One set of panoramic or complete intra-oral x-rays every 36 months 	
<p><u>Basic dental services</u></p>	
<ul style="list-style-type: none"> • Fillings and restorations • Extractions • Anesthesia and sedation • Oral surgery • Emergency care for pain relief • Endodontic services (e.g., root canal) • Periodontal treatment <ul style="list-style-type: none"> ○ Periodontal surgery ○ Debridement ○ Scaling/root planning ○ Localized delivery of anti-microbial agents via controlled release vehicle (arestin) 	<p>You pay a 20% coinsurance for covered basic dental services.</p>
<ul style="list-style-type: none"> • Periodontal maintenance (2 per calendar year) 	<p>You pay a 20% coinsurance for covered major dental services.</p>
<p><u>Major dental services*</u></p>	
<ul style="list-style-type: none"> • Dentures <ul style="list-style-type: none"> ○ Rebasing (1 every 36 months) ○ Relining (1 every 18 months) • Bridges • Veneers • Crowns and crown buildups • Inlays, onlays, and cast restorations 	<p>Note: Dental Services are not included in the annual Maximum Out-of-Pocket Amount.</p>
<p>*Some major services require precertification. Exclusions and limitations are outlined in chapter 4 section 3.1.</p>	

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

Covered Service	What you pay
 <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/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
 <p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>
 <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. Coverage for glucose monitors and test strips is limited to Freestyle and Precision brands produced by Abbott Labs. If you or your physician feel that it is medically necessary for you to use a different monitor or test strips call Member Services (phone numbers are printed on the back cover of this booklet). For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized 	<p>You pay a \$0 copayment for covered diabetes self-monitoring equipment and supplies.</p> <p>You pay 20% coinsurance for Medicare-covered therapeutic shoes or inserts.</p> <p>You pay a \$0 copayment for the diabetes self-management training preventive benefit.</p>


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

Covered Service	What you pay
<p>removable inserts provided with such shoes). Coverage includes fitting.</p> <ul style="list-style-type: none"> • Diabetes self-management training is covered under certain conditions. • Insulin Pumps are covered under the Durable Medical Equipment (DME) benefit. For more information about coverage for DME, please go to the section, “Durable medical equipment (DME) and related supplies”. found in this benefit chart. • Insulin for insulin pumps is covered under the Part B Drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.” <p>*Prior Authorization is required for continuous glucose monitors. In-network providers are responsible to obtain prior authorization.</p>	
<p>Diagnostic colonoscopy</p> <p>Diagnostic colonoscopies are performed to <u>assess</u> or monitor known medical conditions. If you have a history of polyps or other colon condition, or have symptoms indicating potential conditions, then any colonoscopy performed will be diagnostic in nature.</p>	<p>You pay a \$400 copayment for each Medicare-covered diagnostic colonoscopy.</p>
<p>Durable medical equipment (DME) and related supplies*</p> <p>(For a definition of durable medical equipment, go to Chapter 10 and Chapter 3)</p> <p>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at selecthealth.org/medicare.</p>	<p>You pay 0% coinsurance for crutches, canes, or walkers.</p> <p>You pay 20% coinsurance for all other Medicare-covered durable medical equipment and supplies.</p>

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

Covered Service	What you pay
<p>Generally, <i>Select Health Medicare NoRx</i> covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to <i>Select Health Medicare NoRx</i> and using a brand of DME not on our list, we'll continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</p> <p>If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, go to Chapter 7.)</p> <p>*Prior Authorization is required for certain services in this category. Please refer to Chapter 4, Section 2.1 above for a complete list of DME items that require Prior Authorization. In-network providers are responsible to obtain prior authorization.</p>	
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.</p>	<p>You pay a \$130 copayment for each Medicare-covered emergency room visit. This copayment is waived if you are admitted inpatient to the hospital within 24 hours for the same condition. If you are admitted inpatient you will instead pay the applicable inpatient hospital copay.</p> <p>If you get emergency care at an out-of-network</p>


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

Covered Service	What you pay
<p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p> <p>You are covered world-wide for emergency care.</p>	<p>hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.</p>
<p> Health and wellness education programs</p> <p>The Wellness Your Way benefit allows you to decide how to spend your health and wellness dollars.</p> <p>You will receive a Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card) There is an allowance every year that helps you cover out-of-pocket expenses on the following:</p> <ul style="list-style-type: none"> • <i>Fitness Benefits</i> include gym membership, fitness center, or health club. Golf greens fees, ski lift passes and exercise classes. • <i>Health Education classes</i> and services include formal health education programs if they are provided by a certified health educator or qualified licensed health professional and if they are composed of interactive sessions that primarily provide health information, encourage enrollees’ adoption of healthy behaviors, build skills to enhance enrollees’ self-care capabilities, and align with the overall goal to improve participants’ healthy weight management programs. <ul style="list-style-type: none"> ○ Health education services not covered under this plan: alternative or holistic education services. • <i>Nutritional services</i> include individual or group sessions or other fully interactive counseling services of a licensed dietician or other licensed professional with specialization and expertise in nutrition and diet. Weight management programs covered under Wellness Your Way include formal programs such as Weight Watchers or Jenny Craig. 	<p>You pay \$0 copayment for these services.</p> <p>You have a \$250 allowance every year on a Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card) to be used for qualifying supplemental items and services at participating locations through the Wellness Your Way and OTC benefits.</p>

Covered Service	What you pay
<ul style="list-style-type: none"> ○ Weight management services not covered under this plan: purchase of meals or meal supplements. <p>Note: the combined annual allowance is shared with your Over-the-Counter (OTC) drugs and supplies benefit. Details to your OTC benefit can be found in this Benefits Chart under ‘Over-the-Counter (OTC) drugs and supplies’.</p> <p>Your benefit dollars can be spent at participating retail locations as defined above. For additional information please visit your MyBenefits portal at SelectHealth.NationsBenefits.com. Any unused benefit dollars will expire at the end of the year.</p> <p>This benefit is not a replacement for your current standalone benefits and is designed to help offset out-of-pocket expenses. The Wellness Your Way benefit is only for your personal use, cannot be sold or transferred, and has no cash value.</p> <p>Your card must be activated before you use your benefits. You can activate your card at SelectHealth.NationsBenefits.com. To learn more about this benefit, you can call a NationsBenefits Member Experience Advisor at (833) 878-0232 (TTY:711), 24 hours a day, seven days a week, 365 days a year.</p>	
<p>Hearing services</p> <p>For diagnostic hearing and balance evaluations, and routine hearing exams, you will need to use a provider on the Select Health Medicare network. (For information on how to find an audiologist on the Select Health Medicare Network, see chapter 3, section 2.2.)</p> <p><u>Medicare-covered hearing exams:</u> Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p> <p><u>Routine hearing exams:</u> Routine hearing exams to evaluate hearing are covered once per calendar year.</p>	<p>You pay a \$50 copayment for Medicare-covered hearing exams.</p> <p>You pay a \$0 copayment for routine hearing exams.</p>

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

Covered Service	What you pay
<p><u>Hearing Aids</u></p> <p>Hearing aids and exams to fit hearing aids are not covered unless you use an approved audiologist in an Intermountain Health Audiology. (For information on how to find a Hearing aid provider, see chapter 3, section 2.2.)</p> <p>Selected hearing aids purchased through approved Intermountain Health Audiology providers are covered under one of five benefit tiers.</p> <p>The applicable tier for each product depends on the technology and unique features built into the different device(s). The tier fee listed to the right includes the hearing aid, the hearing aid fitting, three follow-up adjustment visits within 12 months of the initial fitting, a 1-year supply of batteries, and a one-time replacement device for loss or damage (in the case of replacement, beneficiary will be charged a \$300 per device programming and fitting fee).</p> <p>Additional accessories or upgrades beyond the devices described as part of this benefit, such as Bluetooth connectivity, are not covered under the hearing aid benefit, but may be available from your provider for an additional fee.</p> <p><u>Tier 1 – Economy</u> Economy level hearing aids provide adequate speech understanding. They are best suited for listening in quiet environments with minimal background noise. They will allow you to turn down the television and communicate well with others one-on-one. They may require manual adjustment to maintain comfort and best speech understanding. Limited to two specific hearing aid models.</p> <p><u>Tier 2 – Essential</u> Essential level hearing aids are similar to the Economy level aids with more options to allow for improved speech understanding and customization. They are also best suited for listening in quiet environments with minimal background noise.</p> <p><u>Tier 3 – Standard</u> Standard level hearing aids have basic noise reduction</p>	<p>Tier 1 – Economy: You pay a \$299 copay per hearing aid.</p> <p>Tier 2 – Essential: You pay a \$675 copay per hearing aid.</p> <p>Tier 3 – Standard: You pay a \$975 copay per hearing aid.</p>

Covered Service	What you pay
<p>capability and provide some automatic features. Better performance than Essential hearing aids but still best suited for listening in quiet places with minimal background noise.</p> <p><u>Tier 4 – Advanced</u> Advanced level hearing aids minimize the effects of background noise and enhance speech understanding and have very good sound quality. They meet the needs of most individuals, even those with active lifestyles who often find themselves in crowds or noisy places. Because many features perform automatically, they require less manual adjustment. This level includes models that are able to sync with most cell phones.</p> <p><u>Tier 5 – Premium</u> Premium level hearing aids have the best sound quality in all environments, quiet and noisy where a lot of background noise might be present. These are especially helpful for that very active individual. They have all the same features as the Advanced device, but even better. With devices in this Tier, you have the option of using the highest and most advanced hearing aid technology available today.</p> <p><u>Tier 6 – Premium+</u> Premium+ level hearing aids are essentially the same as the above listed Premium devices. The additional cost is due to the increased acquisition cost of the devices to the Intermountain audiology provider.</p> <p>Your Intermountain audiologist will help you find the correct hearing aid for your needs and explain which tier the hearing aid falls into.</p>	<p>Tier 4 – Advanced: You pay a \$1,325 copay per hearing aid.</p> <p>Tier 5 – Premium: You pay a \$1,825 copay per hearing aid.</p> <p>Tier 6 – Premium: You pay a \$1,975 copay per hearing aid.</p> <p>Note: Hearing Aids are not included in the annual Maximum Out-of-Pocket Amount.</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>If you are pregnant, we cover:</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>


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

Covered Service	What you pay
<ul style="list-style-type: none"> Up to 3 screening exams during a pregnancy 	
<p>Home health agency care*</p> <p>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but aren't 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>*Prior Authorization may be required for select home health agency care. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$0 copayment for Medicare-covered home health agency care.</p>
<p>Home infusion therapy*</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with our plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring 	<p>You will pay the cost sharing that applies to primary care services, specialist physician services, part b drugs or home health (as described under "Physician/Practitioner Services, including Doctor's Office Visits" and "Medicare Part B prescription drugs" or "Home Health Agency Care") depending on where you received administration or monitoring services</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier <p>*Prior Authorization may be required for select home infusion services. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay these amounts until you reach the out-of-pocket maximum.</p>
<p>Hospice care</p> <p>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</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're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p>For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not <i>Select Health Medicare NoRx</i>.</p> <p>You pay a \$0 copayment for hospice consultation services if performed by a Primary Care Provider.</p> <p>You pay a \$50 copayment for hospice consultation services if performed by a Specialist.</p>

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

Covered Service	What you pay
<p>these services depends on whether you use a provider in our plan’s network and follow plan rules (like if there’s a requirement to get prior authorization).</p> <ul style="list-style-type: none"> • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <p>For services covered by <i>Select Health Medicare NoRx</i> but not covered by Medicare Part A or B: <i>Select Health Medicare NoRx</i> will continue to cover plan-covered services that aren’t covered under Part A or B whether or not they’re related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that’s not related to your terminal prognosis), contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.</p>	
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you’re at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you’re at risk and they meet Medicare Part B coverage rules 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p>
<p>Inpatient hospital care*</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you’re formally admitted</p>	<p>You pay the following copay for Medicare-covered inpatient hospital care each time</p>

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



Covered Service	What you pay
<p>to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Select Health Medicare NoRx provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All 	<p>you are admitted to a facility.</p> <p>You pay a \$500 copayment per day for days 1-5.</p> <p>You pay a \$0 copayment per day for days 6-90.</p> <p>You pay a \$0 copayment per day per day for additional days.</p> <p>The benefits and copays start over each time you are admitted to an inpatient facility.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital</p>

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

Covered Service	What you pay
<p>other components of blood are covered starting with the first pint.</p> <ul style="list-style-type: none"> 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're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>*Prior Authorization is required for Inpatient Hospital Care. In-network providers are responsible to obtain prior authorization.</p>	
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. Our plan covers up to 90 days of inpatient mental health care each time you are admitted. Our plan also covers 60 "lifetime reserve days". These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</p> <p>*Prior Authorization is required for Inpatient Mental Health Care. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay the following copay for Medicare-covered inpatient mental health care each time you are admitted to a facility.</p> <p>You pay a \$400 copayment per day for days 1-5.</p> <p>You pay a \$0 copayment per day for days 6-90.</p> <p>You pay a \$0 copayment per day for lifetime reserve days.</p>
<p>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</p> <p>If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient</p>	<p>You pay the amount you would pay for these services on an outpatient basis. See the applicable</p>

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


Covered Service	What you pay
<p>stay. In some cases, we’ll cover certain services you get while you’re in the hospital or the skilled nursing facility (SNF). Covered services include, but aren’t limited to:</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>sections of this benefit chart for additional information on any of these categories of covered services.</p>
<p>Intermountain Connect Care urgent care</p> <p>Intermountain Connect Care urgent care is a convenient service that provides online access for common medical conditions. You receive access to board-certified practicing providers for Select Health Medicare members 24 hours a day, 7 days a week, through internet enabled computers or mobile (Android/iOS) devices. Find Connect Care on the Intermountain Health MyChart app. Connect Care treats conditions such as stuffy and runny nose, allergies, sore throat, eye infections, earache, cough, painful urination, lower back pain, joint pain or strains, and minor skin problems. Please note that Connect Care urgent care is not for medical emergencies. Please call 911 or go to the nearest emergency room for any emergency care.</p>	<p>You pay a \$0 copayment for each Intermountain Connect Care urgent care visit.</p>
<p>Meals after discharge*</p>	<p>You pay a \$0 copayment for meals after discharge as coordinated by your</p>

Covered Service	What you pay
<p>This benefit is to provide up to 2 meals a day for 14 days of meals after you are discharged from an inpatient acute hospital or skilled nursing facility.</p> <p>Meals will be provided 7 days at a time as coordinated by your Select Health care manager. An additional 7 days will be coordinated with determination of need upon follow up by your care manager.</p> <p>*Prior authorization is required.</p>	<p>Select Health care manager.</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.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services are covered for eligible people 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>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p>Medicare Part B drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:</p>	<p>You pay 0% coinsurance for Avastin Ocular use.</p> <p>You pay 0- 20% coinsurance for Medicare-covered Part B</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug 	<p>chemotherapy drugs and other Part B drugs.</p> <p>You pay 0- 20% coinsurance up to \$35 for a one-month supply for Part B Insulin.</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions. (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) <p>This link will take you to a list of Part B drugs that may be subject to Step Therapy: selecthealth.org/medicare/pharmacy/pharmacy-benefits</p> <p>We also cover some vaccines under our Part B drug benefit.</p> <p>*Prior authorization is required for certain drugs covered under Medicare Part B. Contact us for additional information. (Phone numbers for Member Services are printed on the back cover of this booklet.) In-network providers are responsible to obtain prior authorization.</p> <p>*Step therapy is required on certain Part B drugs. This means you may be required to try a different Part B (medical benefit) or Part D (prescription drug benefit) drug before you take certain Part B drugs. Your cost will not be higher when you take a step therapy drug.</p>	
 <p>Obesity screening and therapy to promote sustained weight loss</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

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

Covered Service	What you pay
<p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>You pay a 10% coinsurance for Medicare-covered opioid treatment program services.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>Covered services include, but aren't 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 of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. 	<p><u>X-Rays</u> You pay a \$0 copayment for Medicare-covered x-rays in your doctor's office or in an outpatient hospital setting.</p> <p><u>Radiation therapy</u> You pay 20% coinsurance for Medicare-covered radiation therapy services.</p> <p><u>Surgical Supplies</u> You pay 20% coinsurance for Medicare-covered surgical supplies not</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. Other outpatient diagnostic tests <p>*Prior Authorization is required for certain services in this category. Please refer to Chapter 4, Section 2.1 above for a complete list of services that require Prior Authorization. In-network providers are responsible to obtain prior authorization.</p>	<p>related to an outpatient surgery or procedure.</p> <p><u>Sleep studies</u> You pay 20% coinsurance for Medicare-covered sleep studies in a certified sleep center.</p> <p>You pay a \$0 copayment for home-based sleep studies administered by your PCP.</p> <p>You pay a \$50 copayment for home-based sleep studies administered by an in-network specialist.</p> <p><u>Non-Nuclear Cardiac Stress Tests</u> You pay 20% coinsurance for Medicare-covered non-nuclear cardiac stress tests.</p> <p><u>Laboratory Tests</u> You pay a \$0 copayment for Medicare-covered lab tests in your doctor's office or in an outpatient hospital setting.</p> <p><u>Blood Services</u> You pay a \$0 copayment for Medicare-covered blood services.</p> <p><u>Advanced Imaging</u> You pay a \$150 copay for Medicare-covered advanced imaging services in a physician office or outpatient</p>

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

Covered Service	What you pay
	<p>facility setting, in addition to any applicable office visit or facility copay.</p> <p><u>Nuclear Medicine</u> You pay a \$300 copay for Medicare-covered advanced imaging or nuclear medicine services in a physician office or outpatient facility setting, in addition to any applicable office visit or facility copay.</p> <p><u>Other Diagnostic Tests</u> You pay a \$0 copayment for Medicare-covered diagnostic tests in your doctor’s office or in an outpatient hospital setting.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you’re an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren’t sure if you’re an outpatient, ask the hospital staff.</p>	<p>You pay a \$400 copayment for Medicare-covered outpatient hospital observation services</p>

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

Covered Service	What you pay
<p>Get more information Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<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 aren't 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 you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>*Prior Authorization is required for certain services in this category. Please refer to Chapter 4, Section 2.1 above for a complete list of services that require Prior Authorization. In-network providers are responsible to obtain prior authorization.</p>	<p><u>Outpatient Procedures.</u> You pay a \$400 copayment for Medicare-covered outpatient procedures.</p> <p><u>Medical Supplies</u> You pay 20% coinsurance for Medicare-covered medical supplies.</p> <p><u>IV Infusion Therapy</u> You pay 20% coinsurance for Medicare-covered IV infusion therapy.</p> <p><u>Chemotherapy</u> You pay 20% coinsurance for Medicare-covered chemotherapy services.</p> <p><u>Blood Transfusion Services</u> You pay 20% coinsurance for Medicare-covered services related to blood transfusions.</p> <p><u>Wound Care</u> You pay a \$50 copayment for Medicare-covered wound care services.</p> <p><u>Other Outpatient Services</u> You pay 20% coinsurance for all other services</p>

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

Covered Service	What you pay
	received in an outpatient hospital setting.
<p>Outpatient mental health care</p> <p>Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>You pay a \$25 copayment for Medicare-covered individual therapy.</p> <p>You pay a \$15 copayment for Medicare-covered group therapy.</p>
<p>Outpatient rehabilitation services*</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p> <p>*Prior Authorization is required for Outpatient Rehabilitation Services. Refer to Chapter 4, Section 2.1 above for additional information. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$20 copayment per visit/encounter for Medicare-covered physical, occupational, or speech therapy services in a specialist's office.</p> <p>You pay a \$20 copayment per visit/encounter for Medicare-covered physical, occupational, or speech therapy services in an outpatient hospital or CORF setting.</p>
<p>Outpatient substance use disorder services*</p> <p>Treatment and counseling for substance abuse performed in an outpatient setting.</p> <p>*Prior Authorization is required for outpatient substance abuse services. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$25 copayment for Medicare-covered individual substance use disorder services in a specialist's office or an outpatient hospital setting.</p> <p>You pay a \$15 copayment for Medicare-covered group substance use</p>

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

Covered Service	What you pay
	disorder services in a specialist's office or an outpatient hospital setting.
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p> <p>*Prior Authorization is required for certain services in this category. Please refer to Chapter 4, Section 2.1 above for a complete list of services that require prior authorization. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$400 copayment for Medicare-covered outpatient surgery in an outpatient hospital setting.</p> <p>You pay a \$250 copayment for Medicare-covered outpatient surgery in an ambulatory surgical center.</p>
<p>Over-the-counter (OTC) drugs and supplies</p> <p>You have an annual allowance to spend on plan-approved OTC items, medications, and products. You will receive a Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card).</p> <p>If you do not use all your benefit amount by the end of the year or prior to disenrolling, the remaining balance will not accumulate to the next plan year.</p> <p>How to get OTC products:</p> <ul style="list-style-type: none"> • Online-visit SelectHealth.NationsBenefits.com. • By Phone – call (833) 878-0232 (TTY users should call 711) • By Mail – Fill out and return the order form in the NationsBenefits/Select Health product catalog. • Retail – Use your Select Health Medicare Flexible Benefits Mastercard® at participating retail locations. <p>Your card must be activated before you use your benefits. You can activate your card at SelectHealth.NationsBenefits.com/activate.</p>	<p>You pay \$0 copayment for these services.</p> <p>You have a combined \$250 allowance every year on your Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card) to be used for qualifying supplemental items and services at participating locations through the OTC and Wellness Your Way benefits</p>

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



Covered Service	What you pay
<p>To learn more about this benefit, you can call a NationsBenefits Member Experience Advisor (833) 878-0232. (TTY users should call 711).</p>	
<p>Partial hospitalization services and Intensive outpatient services*</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p> <p>Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.</p> <p>*Prior Authorization is required for Partial Hospitalization Services. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$140 copayment per day for a Medicare-covered partial hospitalization program.</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 you get 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 PCP, if your doctor orders it to see if you need medical treatment 	<p><u>Office Visits</u></p> <p>You pay a \$0 copayment per office visit with your primary care provider.</p> <p>You pay a \$50 copayment per office visit with your specialist provider.</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> • Certain telehealth services, including: initial or follow-up care, diagnosis, or treatment. Many services are available via telehealth in full or in part, including primary care, behavioral health, cardiology, neurology and other services <ul style="list-style-type: none"> ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment 	<p><u>Office Surgery</u></p> <p>You pay a \$0 copayment for each Medicare-covered surgery when performed in your primary care provider's office.</p> <p>You pay a \$50 copayment for each Medicare-covered surgery when performed in a specialist's office.</p> <p><u>Telehealth Services</u></p> <p>You pay the same amount for Telehealth Services as you do for an in-person visit with your provider.</p> <p>You pay a \$0 copayment for a Telehealth visit with your primary care provider.</p> <p>You pay a \$50 copayment for Telehealth services with your specialist provider.</p> <p><u>Medicare-covered dental services:</u></p> <p>You pay a \$50 copayment for Medicare-covered non-routine dental care.</p>



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

Covered Service	What you pay
<ul style="list-style-type: none"> • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • 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>*Prior Authorization is required for Medicare-covered dental services. In-network providers are responsible to obtain prior authorization.</p>	
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs <p><u>Routine foot care</u></p> <ul style="list-style-type: none"> • 6 visits per calendar year for routine foot care services, such as nail trimming, for any reason &/or conditions not covered by Original Medicare. 	<p>You pay a \$50 copayment per visit for Medicare-covered podiatry services.</p> <p>You pay a \$50 copayment per visit for up to 6 visits for routine foot care services every calendar year.</p>

Covered Service	What you pay
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention</p> <p>If you don’t have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you’re getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. <p>A one-time hepatitis B virus screening.</p>	<p>There is no coinsurance, copayment, or deductible for the PrEP benefit.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 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>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<p>Prosthetic and orthotic devices and related supplies*</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include but aren’t limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.</p> <p>*Prior Authorization is required for certain services in this category. Please refer to Chapter 4, Section 2.1 above for a complete list of services that require prior authorization. In-</p>	<p>You pay 20% coinsurance for Medicare-covered prosthetic devices and related supplies.</p>

Covered Service	What you pay
<p>network providers are responsible to obtain prior authorization.</p>	
<p>Pulmonary rehabilitation services*</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p>*Prior authorization is required. In-network providers are responsible to obtain prior authorization.</p>	<p>You pay a \$0 copayment for each Medicare-covered pulmonary rehabilitation visit.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren’t alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p>


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

Covered Service	What you pay
<p>physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	
<p> Screening for Hepatitis C Virus infection</p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.</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 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p>	<p>You pay a \$0 copayment for Medicare-covered</p>

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


Covered Service	What you pay
<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 6 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, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're 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 Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.</p>	<p>kidney disease education and training.</p> <p>You pay 20% coinsurance for Medicare-covered dialysis treatment.</p> <p>You pay 20% coinsurance for Medicare-covered home dialysis equipment and supplies.</p> <p>You pay 20% coinsurance for Medicare-covered home support services.</p> <p>For inpatient renal dialysis services, the same copays apply as "Inpatient hospital care" listed earlier in this benefit chart.</p>
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)</p> <p>You are covered for up to 100 days each Benefit Period. Covered services include but aren't 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 our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells, and other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs 	<p>You pay the following copay for Medicare-covered skilled nursing facility care each Benefit Period (See definition of Benefit Period in Chapter 12 of this booklet):</p> <p>You pay a \$0 copayment per day for days 1-20.</p> <p>You pay a \$218 copayment per day for days 21-55.</p> <p>You pay a \$0 copayment per day for days 56-100.</p>

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


Covered Service	What you pay
<ul style="list-style-type: none"> • 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 get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</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 or domestic partner is living at the time you leave the hospital <p>*Prior Authorization is required for certain services in this category. In-network providers are responsible to obtain prior authorization.</p>	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Supervised Exercise Therapy (SET)*</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p>	<p>You pay a \$0 copayment for each Medicare-covered SET visit.</p>

Covered Service	What you pay
<p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician’s office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p> <p>*Prior authorization is required. In-network providers are responsible to obtain prior authorization.</p>	
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or, even if you’re inside our plan’s service area, it’s unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.</p>	<p>You pay a \$50 copayment for Medicare-covered services at an urgent care facility.</p> <p>There is no additional copay for labs and/or X-rays performed during your urgent care visit.</p> <p>The Urgent Care copay is waived if you are referred to the Emergency Department or admitted inpatient to the hospital within 24 hours for the same condition. If you are referred to the Emergency Department or admitted inpatient you</p>

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

Covered Service	What you pay
	will instead pay the applicable Emergency Services or Inpatient Hospital copay.
<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 for glaucoma, we 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. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. • For members with a diagnosis of keratoconus we cover contacts to correct vision. <p>Note: For covered medical services (services related to treatment or management of an existing medical condition) you will need to use a provider in the Select Health Medicare Network (for information on how to find a provider on Select Health's network see chapter 3, section 2.2, <i>How to get care from specialists and other network providers</i>).</p> <ul style="list-style-type: none"> • Routine eye exam • Determination of refraction (test to determine your vision hardware prescription) <p>Note: For routine eye exams and refractions, you will need to use a provider on the EyeMed Access network (for information</p>	<p>You pay a \$50 copayment for Medicare-covered non-routine eye exams.</p> <p>You pay a \$0 copayment for routine eye exams with an EyeMed Provider.</p> <p>You pay a \$0 copayment for refractions with an EyeMed Provider.</p> <p>You pay a \$0 copayment for Medicare-covered glaucoma screening, once per year.</p> <p>You pay a \$0 copayment for Medicare-covered diabetic retinopathy screening, once per year.</p> <p>You pay a \$0 copayment for Medicare-covered eyeglasses or contacts following cataract surgery up to the Medicare allowed amount.</p> <p>You pay a \$0 copayment for contacts for members with keratoconus.</p> <p>If the refraction, glaucoma screening, or retinopathy is performed during an eye exam, then you will still be</p>

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

Covered Service	What you pay
<p>on how to find an EyeMed Provider, see Chapter 3, Section 2.2, <i>How to get care from specialists and other network providers</i>).</p>	<p>responsible for the eye exam copay.</p>
<p>Vision Hardware</p> <p>This benefit is administered by EyeMed Vision Care®. Services are only covered when you use a provider that is in the EyeMed Access network such as LensCrafters®, Target Optical®, and most Pearl Vision® locations. (For information on how to find an EyeMed retailer, see chapter 3, section 2.2.)</p> <p>This benefit has an allowance for either any frame, lens and lens options available at provider location or contact lenses (conventional or disposable) once every year.</p>	<p><u>In-Network:</u></p> <p>You pay \$0 for these services.</p> <p>You have a \$200 allowance every year for Vision Hardware.</p> <p><u>Out-of-Network:</u></p> <p>The plan will reimburse up to \$200 for vision hardware.</p> <p>Note: Vision hardware costs are not included in the annual Maximum Out-of-Pocket Amount.</p>
<p> Welcome to Medicare preventive visit</p> <p>Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p>

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

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Compression Stockings	The following are not covered: <ul style="list-style-type: none"> • Below knee, 18-30 pressure • Thigh length • Full length • Waist length • Garter belts • (These supplies may be available under the Over-the-Counter benefit)
Cosmetic surgery or procedures	<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
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)

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

Services not covered by Medicare	Covered only under specific conditions
procedures determined by Original Medicare to not be generally accepted by the medical community	
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Coverage for up to 14 days of meals prior authorized for qualifying members after they are discharged from an inpatient acute hospital or skilled nursing facility.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Incontinence Supplies	These supplies are available under the Over-the-Counter benefit
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Part D Prescription Drugs	Not covered under any condition
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary.
Purchase or rental of home use pulse oximetry equipment and supplies	These supplies are available under the Over-the-Counter benefit

Services not covered by Medicare	Covered only under specific conditions
Routine eye examinations, eyeglasses, Radial keratotomy, LASIK surgery, and other low vision procedure	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Vein Procedures	Vein procedures are only covered when performed at an accredited vein clinic or facility.

Exclusions and Limitations for Select Health Medicare Dental

The following exclusions and limitations apply to your dental coverage.

Exclusions

- Accidental Injury – Repairs for accidental injury to natural teeth, crowns, and the supporting structures surrounding the teeth, resulting from forces external to the mouth, are not covered when the services are covered by any other insurance policy (e.g., medical, automobile, homeowners, commercial liability, government-sponsored health plan).
- Administrative Charges – Services obtained for administrative purposes are not covered. Charges for completing insurance forms, duplication services, interest, finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.
- Caries Susceptibility Tests
- Certain Illegal Activities – Services for an illness, condition, accident, or injury are not covered if it occurred while the member was a voluntary participant in an illegal activity.
- Complications – All Services provided or ordered to treat complications of a non-covered service are not covered.

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

- Cone Beam CT – Cone beam CT or craniofacial data capture, including two- or three-dimensional image reconstruction, is not covered.
- Congenitally Missing Teeth – Services related to congenitally missing teeth are not covered.
- Cosmetic/Aesthetic Procedures
- Debarred Providers – Services from Providers debarred by any state or federal health care program are not covered.
- Excess Charges – Charges from providers and facilities that exceed Select Health's allowed amount for covered services are not covered. You are responsible to pay for excess charges from nonparticipating providers and facilities.
- Fluoride and Fluoride Treatments
- Night Guards or Athletic Mouthguards
- Nitrous Oxide
- No Charge Services – Services that would not be billed by the provider in the absence of dental insurance coverage are not covered.
- Non-Dental Services and Conditions – Non-dental services are not covered, such as fees for hospital services, laboratory tests, prescription and over-the-counter drugs, or other medical services.
- Non-Dentist Treatment – Services provided by anyone other than a licensed dental provider, or a person who is legally permitted to work under the direct supervision of a dentist, are not covered.
- Occlusion – Services intended to correct, alter, or restore dental contour, contact, or occlusion, such as night guards or orthotic appliances, are not covered. Services designed to rebuild or replace chewing surfaces due to unaligned teeth or tooth structure lost from wear, erosion, misalignment, attrition, or abrasion are also not covered.
- Other Insurance Coverage (Auto, Government, Third-Party Liability, etc.) – Expenses for services and treatment that are reimbursed under any other insurance policy (e.g., medical, automobile, homeowners, commercial liability, government-sponsored health plan) or where another third-party is or may be responsible are not covered. This applies whether the insurance is issued to, or otherwise provides Benefits available to the Member, regardless of whether or not the person files a claim under the insurance policy. In addition, services received without cost from any federal, state, or local agency are excluded.
- Precision Attachments/Semi-Precision Attachments
- Related Provider Services – Services provided to a Member by a provider who ordinarily resides in the same household as the member are not covered.

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

- Replacement of Lost, Stolen, or Broken Dental Appliance or Removable Prosthetic – Replacement of any lost, stolen, or broken (not from normal use or wear) dental appliance or removable prosthetic is not covered, regardless of the cause of damage or loss. Dental appliances include, but are not limited to, retainers, dentures, bridges, etc.
- Sealants
- Services Received Before Coverage was Effective or After Coverage Termination
- Space Maintainers
- Standard of Care – Services that are outside the generally accepted standard of care in the dental provider community are not covered.
- Telephone/E-mail Consultations – Charges for provider telephone/e-mail consultations are not covered.
- Temporary Services (e.g., temporary crowns) – Temporary appliances, restorations, or other procedures are not covered. “Temporary” for purposes of this exclusion is a duration less than six months.
- Temporomandibular Joint Dysfunction – Any services, including myotherapy, used to correct or treat any pain, dysfunction, or condition associated with the temporomandibular joints are not covered.
- Tooth Transplantation – All Services relating to a tooth transplantation.
- Treatments to Control Harmful Habits (e.g., tongue thrusts) – Treatments, devices, or appliances used to correct or control harmful habits such as thumb sucking, tongue thrusting, etc., are not covered.
- Unnecessary or Excess Services – Any services or treatment considered by the plan to not be Dentally Necessary or not be in line with the standard of care generally accepted by the dental provider community are not covered.
- War/Military Service – Any treatment of any condition caused by, or arising out of, a Member’s active participation in a war or other insurrection is not covered.

Limitations

- Oral examinations, cleanings, and bitewing x-rays are covered twice per year.
- Panoramic or complete intraoral x-rays are covered once every 36 months.
- Repair or replacement of fillings or restorations is not covered within 24 months of original filling or restoration.
- Repeat endodontic procedures are not covered within 12 months of the original procedure when performed by the same provider.
- Periodontal surgery is covered only once per quadrant every 36 months.

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

- Periodontal debridement is covered only once every 36 months.
- Periodontal scaling or root planing is covered only once per quadrant every 24 months.
- Periodontal maintenance is covered only twice per year in lieu of a cleaning.
- Replacement of bridges, dentures, or other prosthodontic devices due to normal wear or use, loss of remaining teeth, or change in supporting tissue, is covered only after five years from the date of placement.
- Repair and/or adjustment of bridges, dentures, or other prosthodontic devices due to normal wear or use is covered only after six months from the date of placement.
- Rebasing of dentures is covered only once every 36 months.
- Relining of dentures is covered only once every 18 months.
- Replacement of crowns, crown buildups, veneers, inlays, onlays, or cast restorations is covered only once every 5 years.
- Localized delivery of anti-microbial agents via controlled release vehicle (arestin) procedure should not exceed three teeth per quadrant or 30% of the mouth per calendar year.

CHAPTER 5:

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

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

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

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

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

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

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

- You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.

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

- If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

Please 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 back cover of this booklet.)

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we

decide it should be covered, we'll pay for our share of the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

4. When you pay out-of-pocket for health or wellness services covered under the Wellness Your Way benefit

If you pay out of pocket for services that are covered under the Wellness Your Way benefit.

- For example, you attend a gym that is not set up to bill under a covered facility type. Or if your monthly gym membership is paid directly from your bank account.
- Save your receipt or other proof of payment and send a copy to NationsBenefits (the administrator of the Select Health Medicare Benefits Mastercard® Prepaid Card (Flex Card)). Go to the NationsBenefits flex card portal at selecthealth.nationsbenefits.com,
 - You may complete the Reimbursement Requests form, attaching a copy of your proof of payment.
 - You may print a copy of the Reimbursement form and mail it with a copy of your proof of payment to NationsBenefits.
 - Call NationsBenefits at (833) 878-0232 (TTY: 711) if you need help with the reimbursement process.
 - If your coverage with the plan has terminated, contact Select Health Member Services (numbers are printed on the back cover of this booklet).

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months** of the date you got the service or item. Wellness Your Way reimbursement requests for covered services paid during 2025 must be submitted by March 31, 2026. If your coverage ends before December 31, you will have three months following your termination date to submit a request for reimbursement.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website www.selecthealth.org/medicare or call Member Services at **855-442-9900** (TTY users call **711**) and ask for the form.

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

For Medical claims	Select Health Medicare Attn: Medical Claims PO Box 30196 Salt Lake City, UT 84130
For Wellness Your Way reimbursements	NationBenefits 1700 North University Drive Plantation, FL 33322

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

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

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

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

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

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in languages other than English including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at **855-442-9900** (TTY users call **711**).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with **844-208-9012**. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to network providers.

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at **855-442-9900** (TTY users call **711**).

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

We understand the importance and sensitivity of your personal health information, and we have security in place to protect it. Access to your information is limited to those who need it to perform assigned tasks. We restrict access to work areas and use locking filing cabinets and password-protected computer systems. We follow all federal and state laws that govern the use of your health information. We use your health information in written, oral, and electronic formats (and allow others to use it) only as permitted by federal and state laws. These laws give you certain rights regarding your health information.

We participate in organized healthcare arrangements (OHCA) with other entities including but not limited to, Intermountain Healthcare entities, The Intermountain Life and Health Benefit Plan, and the University of Utah Medical Group (with respect to certain defined pediatric specialty services). These OHCA members share information for treatment, payment and healthcare operations to improve, manage, and coordinate your care.

To learn more about activities and see a current list of all OHCA members, visit selecthealth.org/plans/individual/services/Pages/ohca.aspx.

Your Health Information Rights

You may:

- Review and get a paper copy of your policy or claims records as allowed by law, usually within 30 days of your request (you can also ask us to provide a copy in electronic form, and we will do that if we can readily produce it).
- Request and be provided a paper copy of our current Notice of Privacy Practices, or receive an electronic copy by email if you have agreed to receive an electronic copy.

Chapter 6 Your rights and responsibilities

- Ask us to contact you at a specific address or phone number if contacting you at your current address or phone number could endanger you.
- Request and receive an accounting, as specified by law, of certain situations when your information was shared without your consent.
- Receive a notice if Select Health or one of its Business Associates causes a breach of your unsecured information.
- Report a privacy concern and be assured that we will investigate your concern thoroughly, supporting you appropriately, and not retaliate against you in any way (in fact, Select Health will provide you with information on how to report any privacy concerns to the Select Health Privacy Coordinator, the Intermountain Corporate Privacy Office, or the Office for Civil Rights, U. S. Department of Health and Human Services).
- Request in writing other restrictions on the use of your health information or amendments to your health information if you think it is wrong, though we may not always be able to grant these requests.

How Your Health Information is Used**Common Uses of Health Information**

As we provide health insurance benefits, we will gather some of your health information. The law allows us to use or share this health information for the following purposes.

- To receive payment of health coverage premiums and to determine and fulfill our responsibility to provide you benefits. For example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have.
- To improve the overall Intermountain system as well as to help better manage your care. For example, Intermountain has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma, and as part of these programs, we share information with affiliated providers and Intermountain Healthcare to facilitate improved coordination of the care you may receive for these conditions.
- To support healthcare providers in providing treatment.
- To share in limited circumstances health information with your plan sponsor. However, Select Health will only do so if the plan sponsor specifically requests health information for the administration of your health plan and agrees in writing not to use your health information for employment-related actions or decisions.
- To identify health-related services that may be beneficial to your health and then contact you about these services.
- To request your support for improving healthcare by contributing to one of Intermountain's charitable foundations. (If you don't want to be contacted for this

Chapter 6 Your rights and responsibilities

purpose or other fundraising communications, call Intermountain's Privacy Office at **800-442-4845** (TTY users call **711**) to let us know).

- To improve our services to you by allowing companies with whom we contract, called "business associates," to perform certain specialized work for us. The law requires these business associates to protect your health information and obey the same privacy laws that we do.
- To perform a very limited, specific type of health-related research, where the researcher keeps any patient-identifiable information safe and confidential. Intermountain reviews every research request to make sure your privacy is appropriately protected before sharing any health information.
- To law enforcement, but only as authorized by law (e.g., to investigate a crime against Select Health or any of its members).

Required Uses of Health Information

The law sometimes requires us to share information for specific purposes, including the following:

- To the Department of Health to report communicable diseases, traumatic injuries, or birth defects, or for vital statistics, such as a baby's birth.
- To a funeral director or an organ-donation agency when a patient dies, or to a medical examiner when appropriate to investigate a suspicious death.
- To state authorities to report child or elderly abuse.
- To law enforcement.
- To a correctional institution, if a member is an inmate, to ensure the correctional institution's safety.
- To the Secret Service or NSA to protect, for example, the country or the President.
- To a medical device's manufacturer, as required by the FDA, to monitor the safety of a medical device.
- To court officers, as required by law, in response to a court order or a valid subpoena.
- To governmental authorities to prevent serious threats to the public's health or safety.
- To governmental agencies and other affected parties, to report a breach of health-information privacy.
- To a worker's compensation program if a person is injured at work and claims benefits under that program.

Uses According to Your Requests

Chapter 6 Your rights and responsibilities

Your preferences matter. If you let us know how you want us to disclose your information in the following situation, we will follow your directions. You decide if you want us to share any health or payment information related to your care with your family members or friends. Please let us know what you want us to share. If you can't tell us what health or payment information you want us to share, we may use our professional judgment to decide what to share with your family or friends for them to be able to help you.

Uses with Your Authorization

Any sharing of your health information, other than as explained above, requires your written authorization. For example, we will not use your health information unless you authorize us in writing to:

- Share any of your health information with marketing companies.
- Sell any of your health information.

You can change your mind at any time about sharing your health information. Simply notify us in writing. Please understand that we may not be able to get back health information that was shared before you changed your mind.

When enrolling for health insurance coverage on **selecthealth.org** you are giving permission for Select Health to collect the necessary PII to assist in enrolling you for coverage. Providing PII for the purposes of seeking health insurance coverage/enrollment is a voluntary submission of PII under the applicable law. If you do not provide all the necessary PII Select Health may not be able to verify your eligibility for APTC and CSR subsidies or other enrollment options.

Select Health will collect and use this information in accordance with the permissible functions outlined in Federal regulations and agreements between CMS. This information may be shared with the Federally Facilitated Marketplace to verify your eligibility for coverage.

Special Legal Protections for Certain Health Information

Select Health complies with federal laws that require extra protection for your health information if you receive treatment in an addiction treatment program, or from a psychotherapist who keeps notes on your therapy that are kept outside of your regular medical record.

Select Health is prohibited from using or disclosing genetic information for underwriting purposes.

Notice Regarding the Collection and Use of Sexual Orientation and Gender Identity (SOGI) Data

Chapter 6 Your rights and responsibilities

Select Health collects Sexual Orientation and Gender Identity (SOGI) data to enhance the provision of healthcare services and to comply with applicable legal and regulatory requirements. This data collection is intended to facilitate the delivery of culturally competent and member-centered care, particularly for individuals within the LGBTQIA+ community.

Permissible Uses of SOGI Data:

- **Healthcare Service Enhancement:** SOGI data may be utilized to identify and address health disparities, develop targeted interventions, and improve care coordination and management programs.
- **Resource Allocation and Planning:** This data may inform the allocation of resources to communities and populations in need, as well as the planning of community health initiatives and preventive care programs.
- **Member Engagement and Education:** SOGI data may be used to personalize member communications, enhance health literacy, and provide tailored health education materials.
- **Quality Improvement:** This data may be employed to evaluate and improve the quality and effectiveness of healthcare services and to monitor and enhance population health management strategies.
- **Compliance and Reporting:** SOGI data may be used to meet regulatory requirements for data reporting and health equity initiatives, and to support public health reporting and collaboration efforts.

Prohibited Uses of SOGI Data:

- **Non-Discrimination:** Select Health shall not utilize SOGI data for discriminatory practices, including but not limited to, the denial of coverage or services based on SOGI or other protected characteristics.
- **Pricing and Underwriting Restrictions:** SOGI data shall not be used for the adjustment of premiums, deductibles, or other cost-sharing measures, nor shall it influence underwriting decisions in a manner that disadvantages specific populations.
- **Prohibition of Non-Health Related Uses:** Select Health shall not sell or share SOGI data with third parties for purposes unrelated to member health and wellness, nor shall it use such data for marketing purposes without explicit member consent.
- **Data Privacy and Security:** Select Health shall implement and maintain appropriate security measures to protect SOGI data from unauthorized access or breaches. The collection,

Chapter 6 Your rights and responsibilities

storage, and use of SOGI data shall be conducted in accordance with applicable privacy laws and regulations, and with due regard for member consent and transparency.

Right to Refusal:

Members retain the right to decline to provide SOGI data. The provision of such data is voluntary. Select Health acknowledges and respects the individual's right to privacy and the decision to withhold such information.

If You Still Have Questions

Our Privacy Coordinator can help you with any questions you may have about the privacy of your health information. He can also address any privacy concerns you may have about your health information and can help you fill out any forms that are needed to exercise your privacy rights.

This privacy notice became effective on May 26, 2015. We may change this privacy notice at any time, and we may use new ways to protect your health information. We always post our current privacy notice on selecthealth.org.

You can request a copy of this notice by visiting our website or calling our Privacy Office at **801-442-7253** (TTY users call **711**).

This notice of privacy practices describes the practices of Select Health and of our employees and volunteers. (For more information about the specific privacy practices of Intermountain Healthcare and its employees or volunteers working in its hospitals, clinics, doctors' offices or service departments, please contact them directly by visiting intermountainhealthcare.org, or by calling Intermountain's Privacy Office at 800-442-4845. TTY users call 711.)

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

As a member of *Select Health Medicare NoRx*, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at **855-442-9900** (TTY users call **711**):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.

Chapter 6 Your rights and responsibilities

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

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

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

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

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

Chapter 6 Your rights and responsibilities

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at **855-442-9900** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the State Department of Health or with the Department of Public Licensing.

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a

coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

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

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

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

- **Call Member Services at 855-442-9900 (TTY users call 711)**
- **Call your local SHIP at 800-541-7735**
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 855-442-9900 (TTY users call 711)**
- **Call your local SHIP at 800-541-7735**
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections*. (available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at **855-442-9900** (TTY users call **711**).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.

Chapter 6 Your rights and responsibilities

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

CHAPTER 7:

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

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at **855-442-9900** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

The services of SHIP counselors are free.

Medicare

You can also contact Medicare for help.

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

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

Asking for coverage decisions before you get services

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

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

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

Making an appeal

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.

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

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

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

- **Call Member Services at 855-442-9900 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at **855-442-9900** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at selecthealth.org/medicare.)
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call Member Services at **855-442-9900** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at selecthealth.org/medicare.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Section 4.2 Rules and deadlines for different situations

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

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

If you're not sure information applies to you, call Member Services at **855-442-9900** (TTY users call **711**). You can also get help or information from your SHIP.

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Section 5.2 How to ask for a coverage decision**Legal Terms:**

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

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

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

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

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

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

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

- Explains that we'll use the standard deadlines.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

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

For fast Coverage decisions, we use an expedited timeframe.

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Section 5.3 How to make a Level 1 appeal**Legal Terms:**

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

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

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process**Legal Term:**

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

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

Step 1: The independent review organization reviews your appeal.

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

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

- Tells you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at **855-442-9900** (TTY users call **711**) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

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

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at **855-442-9900** (TTY users call **711**) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at **855-442-9900** (TTY users call **711**). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.***How can you contact this organization?***

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at **855-442-9900** (TTY users call **711**) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im.

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

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

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

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

What happens if the answer is no?

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

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

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

If the independent review organization says no:

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

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

Section 7.1 We'll tell you in advance when your coverage will be ending**Legal Term:**

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at **855-442-9900** (TTY users call **711**). Or call your State Health Insurance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

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

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

Legal Term:

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

What happens during this review?

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

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

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

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our 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, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint**Legal Terms:**

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

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

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

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

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

- **Calling Member Services at 855-442-9900 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

respond to your complaint in writing. Please follow the grievance process described below:

- When filing a grievance, please provide the following information:

Your name, address, telephone number, and member identification number; you or your authorized representative's signature and the date signed; a summary of the grievance and any previous contact with us; and a description of the action you are requesting. If you or your authorized representative require assistance in preparing and submitting your grievance, contact our Appeals and Grievances Department at the number shown in Chapter 2 of this booklet.

- You may request an expedited (fast) grievance if:
 - You disagree with our decision to extend the timeframe to make an initial (standard) organization/coverage determination or reconsideration.
 - We deny your request for a 72-hour/fast (expedited) organization/coverage determinations or reconsiderations/redeterminations.
 - We deny your request for a 72-hour/fast (expedited) appeal.
- If you mail the request for an expedited grievance, we will provide oral acknowledgement upon receipt. We will make a determination within 24 hours of receipt of your request.
- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

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

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

Or

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

Section 9.4 You can also tell Medicare about your complaint

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

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in *Select Health Medicare NoRx* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

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

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

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

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

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

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

In certain situations, members of *Select Health Medicare NoRx* may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital

Enrollment time periods vary depending on your situation.

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

Chapter 8 Ending membership in our plan

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

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

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

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

- **Call Member Services at 855-442-9900** (TTY users call **711**)
- Find the information in the ***Medicare & You 2026*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here’s what to do:
Another Medicare health plan	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You’ll automatically be disenrolled from Select Health Medicare NoRx when your new plan’s coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	<ul style="list-style-type: none"> • Enroll in the new Medicare drug plan. • You’ll automatically be disenrolled from Select Health Medicare NoRx when your new plan’s coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	<ul style="list-style-type: none"> • Send us a written request to disenroll. Call Member Services at 855-442-9900 (TTY users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You’ll be disenrolled from Select Health Medicare NoRx when your coverage in Original Medicare starts.

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

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

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

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

SECTION 5 *Select Health Medicare NoRx* must end our plan membership in certain situations

***Select Health Medicare NoRx* must end your membership in our plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
 - If you move or take a long trip, call Member Services at **855-442-9900** (TTY users call **711**) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you let someone else use your membership card to get medical care (We can't make you leave our plan for this reason unless we get permission from Medicare first)

Chapter 8 Ending membership in our plan

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

If you have questions or want more information on when we can end your membership, call Member Services at **855-442-9900** (TTY users call **711**).

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

Select Health Medicare NoRx isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Member Services at **855-442-9900** (TTY users call **711**). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108

Chapter 9 Legal notices

and 423.462, *Select Health Medicare NoRx*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

CHAPTER 10: Definitions

Advanced Imaging – Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Allowed Amount – The amount that providers are paid for covered services. The allowed amount is the amount that a network provider has agreed to accept as payment in full for services provided and is usually less than the provider’s billed charges. For out-of-network providers, the allowed amount is the amount Original Medicare would pay for the services provided.

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

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you’re getting.

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 10 Definitions

care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

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

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

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

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

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

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

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

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

Chapter 10 Definitions

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

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

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

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and health care status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

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

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for our plan premiums and Medicare Part A and Part B premiums don’t count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount. Most services not covered by Original Medicare, such as hearing aids, are not included in the Maximum Out-of-Pocket Amount.

Chapter 10 Definitions

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

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

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

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

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

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

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

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

Chapter 10 Definitions

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

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

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

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

Nuclear Medicine – Nuclear medicine is a medical specialty involving the application of radioactive substances in the diagnosis and treatment of disease.

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

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

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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

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

Prior Authorization – Approval in advance to get services based on specific criteria. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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

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

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

Chapter 10 Definitions

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

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

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

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

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

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

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

Select Health Medicare NoRx Member Services

Method	Member Services Contact Information
Call	(855) 442-9900 Calls to this number are free. October 1 to March 31: Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m., April 1 to September 30: Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday. (Outside of these hours of operation, please leave a message and your call will be returned within one business day.) Member Services 855-442-9900 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	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. See above for days and hours of operation.
Fax	801-442-6580
Write	Select Health Medicare Attn: Member Services PO Box 30196 Salt Lake City, UT 84130
Website	selecthealth.org/medicare

State Health Insurance Assistance Programs: Utah SHIP

State Health Insurance Assistance Programs: Utah 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	800-541-7735
TTY	711 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.

Method	Contact Information
Write	Division of Aging and Adult Services Utah Department of Human Services 195 North 1950 West Salt Lake City, UT 84116
Website	daas.utah.gov/seniors

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

This page intentionally left blank

This page intentionally left blank

IMPORTANT SELECT HEALTH MEDICARE INFORMATION

855-442-9900 (TTY: 711)

October 1 to March 31:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday and Sunday 8:00 a.m. to 8:00 p.m.

April 1 to September 30:

Weekdays 7:00 a.m. to 8:00 p.m., Saturday 9:00 a.m. to 2:00 p.m., closed Sunday.

Outside these hours of operation, please leave a message. Your call will be returned within one business day, or visit **selecthealth.org/medicare**.

Select Health is an HMO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Medicare depends on contract renewal.

H1994_EOC_4028650_016_M