

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Lasso Healthcare Growth (MSA) and Lasso Healthcare Growth Plus (MSA)

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

For questions about this document, please contact Member Services at 1-833-925-2776. (TTY users should call 711). Hours are 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday through Friday from April 1 through September 30.

These plans, Lasso Healthcare Growth (MSA) and Lasso Healthcare Growth Plus (MSA) (collectively “Lasso Healthcare MSA”), are offered by Lasso Healthcare Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Lasso Healthcare Insurance Company. When it says “plan” or “our plan,” it means Lasso Healthcare MSA.)

This document is available for free in Spanish. The information is also available in a different format, including Braille, large print, and audio tapes. Please call Member Services at the number listed above if you need plan information in another format.

Deductible and/or deposit may change on January 1, 2024.

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

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

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1	You are enrolled in Lasso Healthcare MSA, which is a Medicare Medical Savings Account Plan
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You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Lasso Healthcare MSA. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Lasso Healthcare MSA is a Medicare Advantage Medical Savings Account (MSA) Plan. This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare MSA Plan is approved by Medicare and run by a private company. If you are interested in enrolling in a Medicare prescription drug plan or to see what plans are available in your area, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Generally, unless you are new to Medicare or meet a special exception, you can only join during the Medicare fall open enrollment period, which occurs from October 15 to December 7. **If this is your first time enrolling in an MSA plan you may cancel this enrollment by December 15, 2022.**

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

Section 1.2	What is the <i>Evidence of Coverage</i> document about?
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This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

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

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

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with you about how Lasso Healthcare MSA covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

Chapter 1 Getting started as a member

The contract is in effect for months in which you are enrolled in Lasso Healthcare MSA between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Lasso Healthcare MSA after December 31, 2023. We can also choose to stop offering the plan in your service area, after December 31, 2023.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you must reside in the United States for 183 or more days during the year in which the enrollment becomes effective
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you are *not* currently getting hospice care (If you begin hospice care after you enroll, you can remain a member of the plan.)
- -- *and* -- you don't have the following types of additional health benefits:
 - You don't have other health coverage that would pay the MSA plan deductible, including benefits under an employer or union group health plan;
 - You don't get benefits from the Department of Defense (TRICARE) or the Department of Veterans Affairs;
 - You are not a retired Federal government employee and part of the Federal Employee Health Benefits Program (FEHBP); or
 - You are not eligible for Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources).

Section 2.3	Here is the plan service area for Lasso Healthcare MSA
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Lasso Healthcare MSA is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these states: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Washington D.C., West Virginia, and Wyoming.

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of state and into a state that is still within our service area, you must call Member Services in order to update your information.

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

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

Section 2.4	U.S. Citizen or Lawful Presence
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A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Lasso Healthcare MSA if you are not eligible to remain a member on this basis. Lasso Healthcare MSA must disenroll you if you do not meet this requirement.

SECTION 3	Your plan membership card – Use it to get all covered care
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While you are a member of our plan, you must use your membership card whenever you get services covered by this plan. If you do not use your plan membership card when receiving services, you will have to submit a claim to our plan. (For information about submitting a claim, see Chapter 5, *Asking us to pay our share of a bill you have received for covered medical services.*) You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Lasso Healthcare MSA 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.

You will also get a debit card to use to pay for qualified medical expenses with money from your MSA savings account.



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

SECTION 4 Your monthly costs for Lasso Healthcare MSA

Your costs may include the following:

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

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023

Medicare Costs.” If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Lasso Healthcare MSA. (You must continue to pay your Medicare Part B premium).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

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

Your copy of the *Medicare & You 2023* handbook gives information about these premiums in the section called “2023 Medicare Costs.” This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of the *Medicare & You 2023* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2023* handbook from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 5 Keeping your plan membership record up to date

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

We use information in your membership record to provide your coverage. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number

Chapter 1 Getting started as a member

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

If any of this information changes, please let us know by calling Member Services.

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

CHAPTER 2:

*Important phone numbers and
resources*

SECTION 1 Lasso Healthcare MSA contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Lasso Healthcare MSA Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
FAX	1-855-329-5276
WRITE	Lasso Healthcare MSA 225 West Washington St. Suite 450 Chicago, IL 60606
WEBSITE	www.lassohealthcare.com

How to contact Optum Financial

For questions about your MSA savings account and debit card, please contact Lasso Healthcare MSA Member Services and we can connect you to Optum Financial Customer Service department. If you prefer, you may contact Optum Financial directly at the telephone number or address listed below.

Method	Optum Financial Customer Service – Contact Information
CALL	1-855-893-2300 Calls to this number are free. Available 24 hours a day, seven days a week, excluding major U.S. holidays.
TTY	711 Calls to this number are free. Available 24 hours a day, seven days a week, excluding major U.S. holidays.
FAX	1-866-314-9795
WRITE	Optum Financial P.O. Box 271629 Salt Lake City, UT 84127-1629
WEBSITE	www.optumbank.com

Note: Optum Financial or the trustee that you have chosen can only assist you with your MSA account and/or debit card, and are unable to assist you with any benefit issues. For benefit issues, please contact our plan’s Member Services.

For more information about your MSA trustee services provided by Optum Financial, please refer to your deposit agreement and disclosure statement.

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

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

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
WRITE	Lasso Healthcare MSA 225 West Washington St. Suite 450 Chicago, IL 60606
WEBSITE	www.lassohealthcare.com

Method	Appeals for Medical Care – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
FAX	1-800-419-6475
WRITE	Lasso Healthcare MSA Appeal and Grievances Department P.O. Box 1222 Chicago, IL 60690-1222
WEBSITE	www.lassohealthcare.com

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

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

Method	Complaints about Medical Care – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
FAX	1-800-419-6475
WRITE	Lasso Healthcare MSA Appeals and Grievances Department P.O. Box 1222 Chicago, IL 60690-1222
WEBSITE	www.lassohealthcare.com

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

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

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

Method	Payment Requests – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
FAX	1-800-915-4489
WRITE	Lasso Healthcare MSA 225 West Washington St. Suite 450 Chicago, IL 60606
WEBSITE	www.lassohealthcare.com

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

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

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

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

Method	Medicare – Contact Information
WEBSITE	<p data-bbox="505 275 753 306">www.medicare.gov</p> <p data-bbox="505 321 1406 537">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="505 552 1378 621">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="553 636 1414 905" style="list-style-type: none"><li data-bbox="553 636 1414 705">• Medicare Eligibility Tool: Provides Medicare eligibility status information.<li data-bbox="553 720 1414 905">• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="505 919 1362 989">You can also use the website to tell Medicare about any complaints you have about Lasso Healthcare MSA:</p> <ul data-bbox="553 1003 1385 1255" style="list-style-type: none"><li data-bbox="553 1003 1385 1255">• Tell Medicare about your complaint: You can submit a complaint about Lasso Healthcare MSA directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p data-bbox="505 1270 1417 1522">If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

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

- Alabama: State Health Insurance Assistance Program (SHIP)
- Alaska: Department of Health and Human Services
- Arizona: State Health Insurance Assistance Program (SHIP)
- Arkansas: Senior Health Insurance Information Program (SHIIP)
- Delaware: Medicare Assistance Bureau (DMAB)
- Florida: Serving Health Insurance Needs of Elders (SHINE)
- Georgia: GeorgiaCares - State Health Insurance Assistance Program (SHIP)
- Hawaii: State Health Insurance Assistance Program (SHIP)
- Illinois: Senior Health Insurance Program (SHIP)
- Indiana: State Health Insurance Assistance Program (SHIP)
- Kansas: Senior Health Insurance Counseling for Kansas (SHICK)
- Kentucky: State Health Insurance Assistance Program (SHIP)
- Louisiana: Senior Health Insurance Information Program (SHIP)
- Maryland: State Health Insurance Program (SHIP)
- Massachusetts: Serving Health Insurance Needs of Everyone (SHINE)
- Minnesota: State Health Insurance Assistance Program (SHIP)
- Mississippi: State Health Insurance Assistance Program (SHIP)
- Missouri: CLAIM, State Health Insurance Assistance Program (SHIP)
- Montana: State Health and Insurance Assistance Program (SHIP)
- New Hampshire: State Health Insurance Assistance Program (SHIP) – ServiceLink Resource Center
- New Mexico: ADRC – State Health Insurance Assistance Program (SHIP)
- Nevada: State Health Insurance Assistance Program (SHIP)
- North Carolina: Seniors' Health Insurance and Information Program (SHIP)
- North Dakota: State Health Insurance Counseling Program (SHIC)
- Ohio: Ohio Senior Insurance Information Program (OSHIIP)
- Oklahoma: Senior Health Insurance Counseling Program (SHIP)
- Oregon: Senior Health Insurance Benefits Assistance (SHIBA)
- Pennsylvania: Pennsylvania Medicare Education and Decision Insight - PA MEDI
- Rhode Island: Senior Health Insurance Program (SHIP)
- South Carolina: State Health Insurance Assistance Program (SHIP)
- South Dakota: Senior Health Information and Insurance Education (SHIINE)
- Texas: Health Information, Counseling and Advocacy Program (HICAP)
- Utah: State Health Insurance Assistance Program (SHIP)
- Washington D.C.: Health Insurance Counseling Project (HICP)
- West Virginia: State Health Insurance Assistance Program (SHIP)
- Wyoming: State Health Insurance Information Program (WSHIIP)

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: You can select your **STATE** from the dropdown menu and click **GO**. This will take you to a page with phone numbers and resources specific to your state.

Method	Alabama Alabama State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-243-5463
TTY	711
WRITE	RSA Tower, 201 Monroe St, Ste 350 Montgomery, AL 36104
WEBSITE	http://www.alabamaageline.gov/

Method	Alaska Alaska Department of Health and Human Services – Contact Information
CALL	1-800-478-6065
TTY	711
WRITE	550 W 7 th Ave, Ste 1230 Anchorage, AK 99501
WEBSITE	http://dhss.alaska.gov/pages/default.aspx

Method	Arizona Arizona State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-432-4040
TTY	711
WRITE	1789 W Jefferson St (Site Code 950A) Phoenix, AZ 85007
WEBSITE	https://des.az.gov/services/older-adults/medicare-assistance

Method	Arkansas Arkansas Senior Health Insurance Information Program (SHIIP) – Contact Information
CALL	1-800-224-6330
TTY	711
WRITE	1200 W 3 rd St Little Rock, AR 72202
WEBSITE	https://insurance.arkansas.gov/pages/consumer-services/senior-health/

Method	Delaware Delaware Medicare Assistance Bureau (DMAB) – Contact Information
CALL	1-800-336-9500
TTY	711
WRITE	1351 West North St, Ste 101 Dover, DE 19904
WEBSITE	https://insurance.delaware.gov/divisions/dmab/

Method	Florida Serving Health Insurance Needs of Elders (SHINE) – Contact Information
CALL	1-800-963-5337
TTY	1-800-955-8770
WRITE	4040 Esplanade Way, Ste 270 Tallahassee, FL 32399-7000
WEBSITE	https://floridashine.org/

Method	Georgia GeorgiaCares - State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-866-552-4464
TTY	711
WRITE	2 Peachtree St NW, 33 rd Fl Atlanta, GA 30303
WEBSITE	https://www.mygeorgiacares.org/

Method	Hawaii Hawaii State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-888-875-9229
TTY	711
WRITE	Executive Office on Aging, Hawaii State Department of Health, No. 1 Capitol District, 250 S Hotel St, Ste 406 Honolulu, HI 96813
WEBSITE	https://www.hawaiiiship.org/

Method	Illinois Senior Health Insurance Program (SHIP) – Contact Information
CALL	1-800-252-8966
TTY	711
WRITE	One Natural Resources Way, Ste 100 Springfield, IL 62702-1271
WEBSITE	https://www2.illinois.gov/aging/ship/Pages/default.aspx

Method	Indiana State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-452-4800
TTY	1-866-846-0139
WRITE	311 W Washington St, Ste 300 Indianapolis, IN 46204-2787
WEBSITE	https://www.in.gov/idoi/2495.htm

Method	Kansas Senior Health Insurance Counseling for Kansas (SHICK) – Contact Information
CALL	1-800-860-5260
TTY	711
WRITE	New England Building 503 S Kansas Ave Topeka, KS 66603-3404
WEBSITE	http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Method	Kentucky State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-877-293-7447
TTY	711
WRITE	275 E Main St, 3E-E Frankfort, KY 40621
WEBSITE	https://chfs.ky.gov/agencies/dail/pages/ship.aspx

Method	Louisiana Senior Health Insurance Information Program (SHIIP) – Contact Information
CALL	1-800-259-5300
TTY	711
WRITE	1702 N Third St P.O. Box 94214 Baton Rouge, LA 70802
WEBSITE	http://www.ldi.la.gov/consumers/senior-health-shiip

Method	Maryland State Health Insurance Program (SHIP) – Contact Information
CALL	1-800-243-3425
TTY	711
WRITE	301 W Preston St, Ste 1007 Baltimore, MD 21201
WEBSITE	https://.aging.maryland.gov/Pages/state-health-insurance-program.aspx

Method	Massachusetts Serving Health Insurance Needs of Everyone (SHINE) – Contact Information
CALL	1-800-243-4636
TTY	1-800-439-2370
WRITE	One Ashburton Pl, 5 th Fl Boston, MA 02108
WEBSITE	https://www.mass.gov/health-insurance-counseling

Method	Minnesota Minnesota State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-333-2433
TTY	711
WRITE	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164
WEBSITE	https://mn.gov/board-on-aging/direct-services/senior-linkage-line

Method	Mississippi State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-601-359-4500
TTY	711
WRITE	200 S Lamar St Jackson, MS 39201
WEBSITE	http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Method	Missouri CLAIM, State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-390-3330
TTY	711
WRITE	1105 Lakeview Ave Columbia, MO 65201
WEBSITE	http://missouriclaim.org/

Method	Montana Montana State Health and Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-551-3191
TTY	711
WRITE	1100 N Last Chance Gulch, 4 th Fl Helena, MT 59601
WEBSITE	https://dphhs.mt.gov/SLTC/aging/SHIP.aspx

Method	New Hampshire New Hampshire State Health Insurance Assistance Program (SHIP) – ServiceLink Resource Center – Contact Information
CALL	1-866-634-9412
TTY	711
WRITE	N/A
WEBSITE	http://www.servicelink.nh.gov/medicare/index.htm

Method	New Mexico New Mexico ADRC – State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-432-2080
TTY	1-505-476-4937
WRITE	2550 Cerillos Rd Santa Fe, NM 87505
WEBSITE	http://www.nmaging.state.nm.us/

Method	Nevada State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-307-4444
TTY	711
WRITE	3416 Goni Rd, Ste D-132 Carson City, NV 89706
WEBSITE	http://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

Method	North Carolina Seniors' Health Insurance and Information Program (SHIIP) – Contact Information
CALL	1-855-408-1212
TTY	711
WRITE	Albemarle Building, 325 N Salisbury St Raleigh, NC 27603
WEBSITE	https://www.ncdoi.gov/consumers/medicare-and-seniors-healthinsurance-information-program-shiip

Method	North Dakota State Health Insurance Counseling Program (SHIC) – Contact Information
CALL	1-888-575-6611
TTY	1-800-366-6888
WRITE	600 E Boulevard Ave Bismarck, ND 58505-0320
WEBSITE	https://www.insurance.nd.gov/shic-medicare

Method	Ohio Ohio Senior Insurance Information Program (OSHIIP) – Contact Information
CALL	1-800-686-1578
TTY	711
WRITE	50 W Town St, Ste 300 Columbus, OH 43215
WEBSITE	https://insurance.ohio.gov/wps/portal/gov/odi/consumers/medicare

Method	Oklahoma Senior Health Insurance Counseling Program (SHIP) – Contact Information
CALL	1-800-763-2828
TTY	711
WRITE	400 NE 50 th St Oklahoma City, OK 73105
WEBSITE	https://www.oid.ok.gov/consumers/information-for-seniors/senior-healthinsurance-counseling-program-ship/

Method	Oregon Senior Health Insurance Benefits Assistance (SHIBA) – Contact Information
CALL	1-800-722-4134
TTY	711
WRITE	P.O. Box 14480 Salem, OR 97309
WEBSITE	http://www.oregonshiba.org

Method	Pennsylvania Pennsylvania Medicare Education and Decision Insight – PA MEDI – Contact Information
CALL	1-800-783-7067
TTY	711
WRITE	555 Walnut St, 5th Fl Harrisburg, PA 17101-1919
WEBSITE	https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

Method	Rhode Island Senior Health Insurance Program (SHIP) – Contact Information
CALL	1-401-462-3000
TTY	1-401-462-0740
WRITE	25 Howard Ave, Bldg. 57 Cranston, RI 02920
WEBSITE	http://oha.ri.gov/

Method	South Carolina State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-868-9095
TTY	711
WRITE	1301 Gervais St, Ste 350 Columbia, SC 29201
WEBSITE	http://aging.sc.gov/

Method	South Dakota Senior Health Information and Insurance Education (SHIINE) – Contact Information
CALL	Eastern South Dakota: 877-331-4834 Central South Dakota: 877-331-4834 Western South Dakota: 877-286-9072
TTY	711
WRITE	700 Governors Dr Pierre, SD 57501-2291
WEBSITE	http://shiine.net/

Method	Texas Texas Health Information, Counseling and Advocacy Program (HICAP) – Contact Information
CALL	1-800-252-9240
TTY	711
WRITE	701 W 51 st St, MC: W275 Austin, TX 78751
WEBSITE	https://hhs.texas.gov/services/health/medicare

Method	Utah State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-541-7735
TTY	711
WRITE	195 N 1950 W Salt Lake City, UT 84116
WEBSITE	https://daas.utah.gov/seniors/#shiip

Method	Washington D.C. Health Insurance Counseling Project (HICP) – Contact Information
CALL	1-202-727-8370
TTY	711
WRITE	500 K St NE Washington, D.C. 20002
WEBSITE	https://dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship

Method	West Virginia State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-877-987-4463
TTY	711
WRITE	1900 Kanawha Blvd E Charleston, WV 25305
WEBSITE	http://www.wvship.org

Method	Wyoming Wyoming State Health Insurance Information Program (WSHIP) – Contact Information
CALL	1-800-856-4398
TTY	711
WRITE	106 W Adams Ave Riverton, WY 82501
WEBSITE	http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

SECTION 4 Quality Improvement Organization

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

- **KEPRO:** Alabama, Alaska, Arkansas, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Wyoming
- **Livanta BFCC-QIO Program:** Arizona, Delaware, Hawaii, Illinois, Indiana, Kansas, Maryland, Minnesota, Missouri, Nevada, Ohio, Pennsylvania, Washington D.C., West Virginia

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

You should contact the Quality Improvement Organization in any of these situations:

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

Method	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, and South Carolina’s Quality Improvement Organization – Contact Information
CALL	1-888-317-0751
TTY	711
WRITE	KEPRO 5201 W Kennedy Blvd, Ste 900 Tampa, FL 33609
WEBSITE	https://keproqio.com/

Method	Arizona, Hawaii, and Nevada’s Quality Improvement Organization – Contact Information
CALL	1-877-588-1123
TTY	1-855-887-6668
WRITE	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202 Annapolis Junction, MD 20701
WEBSITE	https://livantaqio.com/en

Method	Arkansas, Louisiana, New Mexico, Oklahoma, and Texas’ Quality Improvement Organization – Contact Information
CALL	1-888-315-0636
TTY	711
WRITE	KEPRO 5201 W Kennedy Blvd, Ste 900 Tampa, FL 33609
WEBSITE	https://keproqio.com/

Method	Delaware, , Pennsylvania, Washington D.C., and West Virginia’s Quality Improvement Organization – Contact Information
CALL	1-888-396-4646
TTY	1-888-985-2660
WRITE	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202 Annapolis Junction, MD 20701
WEBSITE	https://livantaqio.com/en

Method	Illinois, Indiana, Minnesota, and Ohio’s Quality Improvement Organization – Contact Information
CALL	1-888-524-9900
TTY	1-888-985-8775
WRITE	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202 Annapolis Junction, MD 20701
WEBSITE	https://livantaqio.com/en

Method	Kansas and Missouri's Quality Improvement Organization – Contact Information
CALL	1-888-755-5580
TTY	1-888-985-9295
WRITE	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202 Annapolis Junction, MD 20701
WEBSITE	https://livantaqio.com/en

Method	Montana, North Dakota, South Dakota, Utah, and Wyoming's Quality Improvement Organization – Contact Information
CALL	1-888-317-0891
TTY	711
WRITE	KEPRO 5201 W Kennedy Blvd, Ste 900 Tampa, FL 33609
WEBSITE	https://keproqio.com/

Method	Massachusetts, New Hampshire, and Rhode Island's Quality Improvement Organization – Contact Information
CALL	1-888-319-8452
TTY	711
WRITE	KEPRO 5201 W Kennedy Blvd, Ste 900 Tampa, FL 33609
WEBSITE	https://keproqio.com/

Method	Alaska and Oregon’s Quality Improvement Organization – Contact Information
CALL	1-888-305-6759
TTY	711
WRITE	KEPRO 5201 W Kennedy Blvd, Ste 900 Tampa, FL 33609
WEBSITE	https://keproqio.com/

SECTION 5 Social Security

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” are:

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

To find out more about Medicaid and its programs, contact your state Medicaid agency. (Please note that people with Medicaid coverage are not eligible for a Medicare MSA plan.)

Method	Alabama Alabama Medicaid – Contact Information
CALL	1-334-242-5000
TTY	1-800-253-0799
WRITE	P.O. Box 5624 Montgomery, AL 36103
WEBSITE	https://medicaid.alabama.gov/

Method	Alaska Alaska Department of Health and Social Services– Contact Information
CALL	1-800-780-9972
TTY	711
WRITE	N/A
WEBSITE	http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx

Method	Arizona Arizona Health Care Cost Containment System (AHCCCS) – Contact Information
CALL	1-855-432-7587 M-F 8 a.m. – 5 p.m.
TTY	1-800-842-6520
WRITE	801 E Jefferson St Phoenix, AZ 85034
WEBSITE	https://www.azahcccs.gov/

Method	Arkansas Arkansas Medicaid – Contact Information
CALL	1-800-482-8988 M-F 8 a.m. – 4:30 p.m.
TTY	711
WRITE	Donaghey Plaza South P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437
WEBSITE	https://humanservices.arkansas.gov/

Method	Delaware Delaware Health and Social Services – Contact Information
CALL	1-800-843-7271 M-F 8 a.m. – 4:30 p.m.
TTY	711
WRITE	Lewis Building 1901 N DuPont Hwy New Castle, DE 19720
WEBSITE	https://www.dhss.delaware.gov/dhss/dmma/

Method	Florida Statewide Medicaid Managed Care – Contact Information
CALL	1-877-711-3662 M-TH 8a.m. – 8p.m., F 8a.m. – 7p.m.
TTY	1-866-467-4970
WRITE	P.O. Box 5197, MS 62 Tallahassee, FL 32314
WEBSITE	https://www.flmedicaidmanagedcare.com/

Method	Georgia Georgia Gateway – Contact Information
CALL	1-877-423-4746 M-F 8 a.m. – 5 p.m.
TTY	1-800-255-0135 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	2 Peachtree St NW, 19th Fl Atlanta, GA 30303
WEBSITE	https://gateway.ga.gov/

Method	Hawaii Hawaii Department of Human Services, Med-QUEST – Contact Information
CALL	1-808-524-3370
TTY	1-808-692-7182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	801 Dillingham Blvd. 3 rd Fl Honolulu, HI 96817
WEBSITE	https://medquest.hawaii.gov/

Method	Illinois Illinois Department of Healthcare and Family Services – Contact Information
CALL	1-800-843-6154 M-F 8 a.m. – 5 p.m.
TTY	1-800-447-6404 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	201 S Grand Ave E Springfield, IL 62763-0001
WEBSITE	https://www2.illinois.gov/hfs/Pages/default.aspx

Method	Indiana Indiana Medicaid – Contact Information
CALL	1-800-457-4584
TTY	711
WRITE	N/A
WEBSITE	https://www.in.gov/medicaid/members/

Method	Kansas KanCare – Contact Information
CALL	1-800-792-4884
TTY	711
WRITE	N/A
WEBSITE	http://www.kancare.ks.gov/

Method	Kentucky Kentucky Cabinet for Health and Family Services – Contact Information
CALL	1-800-372-2973
TTY	1-800-627-4702 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	275 E Main St Frankfort, KY 40621
WEBSITE	https://chfs.ky.gov/

Method	Louisiana Louisiana Department of Health – Contact Information
CALL	1-888-342-6207 M-F 8 a.m. – 4:30 p.m.
TTY	711
WRITE	P.O. Box 629 Baton Rouge, LA 70821
WEBSITE	http://ldh.la.gov/

Method	Maryland Maryland Department of Health – Contact Information
CALL	1-877-463-3464 M-F 8:30 a.m. – 5 p.m.
TTY	711
WRITE	201 W Preston St Baltimore, MD 21201
WEBSITE	https://mmcp.health.maryland.gov/Pages/home.aspx

Method	Massachusetts MassHealth – Contact Information
CALL	1-800-841-2900 M-F 8a.m. – 5p.m.
TTY	1-800-497-4648
WRITE	100 Hancock St, 6 th Fl Quincy, MA 02171
WEBSITE	https://www.mass.gov/orgs/masshealth

Method	Minnesota Department of Human Services
CALL	1-800-657-3739
TTY	1-800-627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	P.O. Box 64993 St. Paul, MN 55164-0993
WEBSITE	https://mn.gov/dhs/

Method	Mississippi Mississippi Division of Medicaid – Contact Information
CALL	1-800-421-2408
TTY	1-228-206-6062 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	550 High St, Ste 1000 Jackson, MS 39201
WEBSITE	https://medicaid.ms.gov/

Method	Missouri MO HealthNet – Contact Information
CALL	1-855-373-4636 M-F 6a.m. – 6:30p.m., Sat. 8a.m. – 5p.m.
TTY	711
WRITE	615 E 13 th St Kansas City, MO 64106
WEBSITE	https://mydss.mo.gov/healthcare

Method	Montana Montana Department of Public Health and Human Services – Contact Information
CALL	1-888-706-1535 M-F 8a.m. – 5p.m.
TTY	711
WRITE	P.O. Box 202925 Helena, MT 59620
WEBSITE	https://dphhs.mt.gov/MontanaHealthcarePrograms

Method	Nevada Department of Health and Human Services – Contact Information
CALL	1-877-638-3472
TTY	711
WRITE	P.O. Box 30042 Reno, NV 89520
WEBSITE	https://www.medicaid.nv.gov/

Method	New Hampshire Department of Health and Human Services – Contact Information
CALL	1-800-852-3345
TTY	1-800-735-2964
WRITE	NH DHHS CHAP Unit 129 Pleasant St, Thayer Bldg. Concord, NH 03301
WEBSITE	https://www.dhhs.nh.gov/ombp/medicaid/

Method	North Carolina NC Medicaid – Contact Information
CALL	1-888-245-0179
TTY	711
WRITE	2501 Mail Service Center Raleigh, NC 27699-2501
WEBSITE	https://medicaid.ncdhhs.gov/medicaid

Method	New Mexico NM Human Services Department – Contact Information
CALL	1-888-997-2583
TTY	1-855-227-5485 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	P.O. Box 2348 Santa Fe, NM 87504-2348
WEBSITE	https://www.hsd.state.nm.us/LookingForAssistance/Default.aspx

Method	North Dakota North Dakota Department of Human Services – Contact Information
CALL	1-800-755-2604
TTY	1-800-366-6888 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	600 E Blvd Ave, Dept 325 Bismarck, ND 58505-0250
WEBSITE	http://www.nd.gov/dhs/services/medicalserv/medicaid/

Method	Ohio Department of Medicaid – Contact Information
CALL	1-800-324-8680
TTY	711
WRITE	50 W Town St, Ste 400 Columbus, Ohio 43215
WEBSITE	https://medicaid.ohio.gov/

Method	Oklahoma Health Care Authority – Contact Information
CALL	1-800-987-7767
TTY	711
WRITE	4345 N Lincoln Blvd Oklahoma City, OK 73105
WEBSITE	http://www.okhca.org/

Method	Oregon Health Authority – Contact Information
CALL	1-877-398-9238
TTY	711
WRITE	500 Summer St NE, E-20 Salem, OR 97301-1097
WEBSITE	https://www.oregon.gov/oha/

Method	Pennsylvania Pennsylvania Department of Human Services – Contact Information
CALL	1-800-692-7462
TTY	1-800-451-5886
WRITE	P.O. Box 2675 Harrisburg, PA 17105
WEBSITE	http://www.dhs.pa.gov/

Method	Rhode Island Health Source RI – Contact Information
CALL	1-800-745-6575
TTY	1-800-745-5555 or 711
WRITE	P.O. Box 8709 Cranston, RI 02920-8787
WEBSITE	http://www.dhs.ri.gov/

Method	South Carolina Healthy Connections – Contact Information
CALL	1-888-549-0820
TTY	711
WRITE	P.O. Box 8206 Columbia, SC 29202-8206
WEBSITE	https://www.scdhhs.gov/

Method	South Dakota South Dakota Department of Social Services – Contact Information
CALL	1-866-718-0084
TTY	711
WRITE	700 Governors Dr Pierre, SD 57501
WEBSITE	http://dss.sd.gov/medicaid/

Method	Texas Texas Health and Human Services – Contact Information
CALL	1-800-252-8263
TTY	711 or 1-800-735-2989
WRITE	4900 N Lamar Blvd Austin, TX 78751-2316
WEBSITE	https://hhs.texas.gov/services/health/medicaid-chip

Method	Utah Utah Department of Health – Contact Information
CALL	1-800-662-9651 M-W and F 8 a.m. – 5 p.m. Th 11 a.m. – 5 p.m.
TTY	711
WRITE	P.O. Box 143106 Salt Lake City, UT 84114-3106
WEBSITE	https://medicaid.utah.gov/

Method	Washington D.C. DC Medicaid – Contact Information
CALL	1-855-532-5465 M-F 8 a.m. – 6 p.m.
TTY	711
WRITE	N/A
WEBSITE	https://dchealthlink.com/individuals/medicaid

Method	West Virginia Department of Health and Human Resources – Contact Information
CALL	1-877-716-1212
TTY	711
WRITE	1 Davis Sq, Ste 100 E Charleston, WV 25301
WEBSITE	https://dhhr.wv.gov/

Method	Wyoming Wyoming Department of Health – Contact Information
CALL	1-855-294-2127
TTY	1-855-329-5204 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	122 W 25 th St, 4 th Fl W Cheyenne, WY 82001
WEBSITE	https://health.wyo.gov/healthcarefin/medicaid/

SECTION 7 How to contact the Railroad Retirement Board

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov/

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

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

CHAPTER 3:

*Using the plan for your medical
services*

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

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

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

Section 1.1	What are providers and covered services?
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- **“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.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

Lasso Healthcare MSA will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider in the United States who is eligible to provide services under Original Medicare.**
 - You must show your plan membership card every time you visit a provider. A provider can decide at each visit whether to accept the payment amount, and thus whether to treat you. You may obtain plan services and equipment from any licensed provider in the United States.

Lasso Healthcare MSA does **not** require you to obtain approval in advance for medically-necessary covered services. If you have any questions about whether we will pay for any medical service that you are considering, you have the right to ask us whether we will cover it before you get it.

Section 1.3 Medical savings accounts and prescription drug coverage

The law does not allow Medicare Advantage MSA plans to offer Medicare prescription drug coverage. If you have a Medicare MSA plan, you can, however, also join a Medicare prescription drug plan to get coverage. Any money that you use from your MSA savings account on drug plan deductibles or cost sharing will **not** count towards your MSA plan deductible, but it will count towards your drug plan's out-of-pocket costs. If you are interested in enrolling in a Medicare prescription drug plan or to see what plans are available in your area, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Generally, unless you are new to Medicare or meet a special exception, you can only join during the Medicare fall open enrollment period, which occurs from October 15 to December 7.

Note that even if you are not enrolled in a Medicare prescription drug plan, money spent from your MSA savings account on prescription drugs are considered “qualified medical expenses” for tax-reporting purposes and are not taxed. See the discussion on tax-reporting responsibilities for members of MSAs in Chapter 6, Section 2.2 (*Special tax-reporting responsibilities of members of a Medicare MSA plan*) for more information on qualified medical expenses.

SECTION 2 How to use the money in your medical savings account

Section 2.1 How does the medical savings account work?

The plan makes the deposit into your medical savings account at the beginning of each calendar year. (Except for those who become entitled to Medicare in the middle of the year and enroll in the plan at that time—these members receive their deposit in the first month they are covered under the plan.) Only the plan can make deposits into your account; you can't deposit your own money. The deposit amount will be less than your deductible amount.

You can use the money in your account to pay for medical expenses, but only Medicare Part A and Part B covered services count toward your deductible. (For more information about what types of expenses you can use the money for, see Section 2.2.)

- If you use all of the money in your account and haven't met your deductible, you must pay for all of your medical expenses out-of-pocket until you reach your deductible.
- If you don't use all of the money in your account, the money left in your account at the end of the year will remain in your account. If you stay with the plan next year, a new deposit will be added to any leftover amount.

Once you get your initial deposit, you may move the deposit to a savings account that's offered through your own bank or financial institution. If you move your deposit, you will be responsible for keeping track of your account balance.

How can I access the money in my account?

You can access the money in your account through the debit card provided by Optum Financial.

Section 2.2	What types of expenses can the money in the account be used for?
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You can use the money in your account to pay for medical expenses, but **only Medicare Part A and Part B covered services count toward your deductible**. You are responsible for handling the money in your account. This includes deciding which types of expenses to pay with the money in your account.

To avoid taxes and penalties, you must use the money in your account for Qualified Medical Expenses. Qualified Medical Expenses are the same types of services and products that could be deducted as medical expenses on your yearly income tax return. Again, only Medicare Part A and B covered services count toward your deductible:

- Some services, like doctors' visits, lab tests, and hospital stays, are Qualified Medical Expenses and are also covered by Medicare Part A or Part B. If you use the money in your account for this type of expense, the money won't be taxed *and* it will count toward your plan deductible.
- Other services, like dental care, vision care, and Part D drugs, are Qualified Medical Expenses, but aren't covered by Medicare Part A or Part B. If you use the money in your account for this type of expense, the money will not be taxed. However, these expenses won't count toward your deductible.

To avoid a tax on withdrawals from your account, you need to file Form 1040, U.S. Individual Income Tax Return, and Form 8853 each year to report your Qualified Medical Expenses. For a complete list of the services and products that count as Qualified Medical Expenses and for other tax information, call the Internal Revenue Service at 1-800-TAX-FORM (1-800-829-3676). Ask for a free copy of the IRS publication #502, "Medical and Dental Expenses." You can also request the IRS publication #969 to get more information about the tax Form 8853, or visit www.irs.gov on the Web and select "Forms and Publications" to view or print copies of the publications.

If you use the money in your account for non-qualified expenses, it will be taxed as part of your income and will also be subject to an additional 50% tax penalty. Each year, you should get a 1099-SA form from your MSA trustee that includes all of the withdrawals from your account. You will need to show that you have had qualified medical expenses in at least this amount, or you may have to pay taxes and additional penalties.

For more information about your tax reporting responsibilities, go to Chapter 6, Section 2.2.

Section 2.3 How can you keep track of your expenses?

You should keep any health care bills or receipts you get to make it easy to summarize your account usage for tax purposes. It may be helpful to keep this information in one place.

If you keep your deposit in the trustee we have selected, you will get a monthly statement that lists your account activity. You can also get information on whether your expenses count toward your deductible.

If you move your deposit to a different trustee or financial institution, you are responsible for tracking your own expenses.

SECTION 3 How to get services when you have an emergency or during a disaster

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval from our plan. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

What is covered if you have a medical emergency?

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

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

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

Section 3.2 Getting care during a disaster

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

Please visit the following website: www.lassohealthcare.com for information on how to obtain needed care during a disaster.

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

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

Before you reach your deductible, you must pay the full cost of your covered services. Even though you must pay for the services, you must submit a claim to our plan so that we can count your expenses towards your deductible.

After you meet the deductible, we will pay for your covered services. If you receive a bill, you should not pay it – you should submit the bill to us for payment. If you have already paid the bill, you should submit a payment request to us so that we can pay you back.

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

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

Lasso Healthcare MSA covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached does not 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.

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

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

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

Section 5.1 What is a “clinical research study”?
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A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. Therefore, if you have met your yearly deductible, you will pay nothing for the items and services you receive as part of the study. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

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

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

Do you want to know more?

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

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

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan’s coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following condition applies:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

Medicare Inpatient Hospital coverage limits apply; see the benefits chart in Chapter 4 for information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Lasso Healthcare MSA, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Call Member Services for more information.

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

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

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Lasso Healthcare MSA 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 Lasso Healthcare MSA or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

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

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**SECTION 1 Understanding your out-of-pocket costs for covered services**

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

Section 1.1 Types of out-of-pocket costs you may pay for your covered services
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The only type of out-of-pocket costs you have in our plan is your yearly deductible. The “**deductible**” is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your yearly deductible.)

Section 1.2 Your yearly deposit and yearly plan deductible
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Our plan makes a yearly deposit into your medical savings account. The plan also has a deductible that you must meet before the plan pays for your covered services. The table below provides more information about the deposit and deductible.

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**Deposit and Deductible Amounts**

Plan Name	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Deposit/Deductible	Amount	Amount
Yearly Deposit This is the amount that Medicare deposits into your medical savings account. You can use the money in your account to pay your health care costs, including health care costs that aren't covered by Medicare. (But only funds used to pay for Medicare Part A and Part B services will count toward your yearly deductible.)	\$2,000 This is how much the plan deposits in your medical savings account.	\$3,000 This is how much the plan deposits in your medical savings account.
Yearly Deductible This is the amount you have to pay out-of-pocket for covered Medicare Part A and Part B services before the plan will pay for your covered services. Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you meet your deductible, the plan will pay 100% of the costs for covered Part A and Part B services for the rest of the calendar year.	\$5,000 This is how much you must pay for your Part A and Part B services before the plan will pay for your covered services.	\$8,000 This is how much you must pay for your Part A and Part B services before the plan will pay for your covered services.

Section 1.3	Our plan does not allow providers to “balance bill” you
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As a member of Lasso Healthcare MSA, an important protection for you is that, once you meet your deductible, we don't allow providers to bill you for any additional charges for services covered under our plan (called “balance billing”). This protection applies even if we pay less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

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

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

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are provided to our members.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.



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

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as:</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, etc. disease); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Acupuncture for chronic low back pain (continued) acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>		
<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. <p>Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered 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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Cervical and vaginal cancer screening 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 are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> We cover only Manual manipulation of the spine to correct subluxation 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> Guaiac-based fecal occult blood test (gFOBT) Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Durable medical equipment (DME) and related supplies (For a definition of “durable medical equipment,” see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at <i>[insert URL]</i>.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Emergency care Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This plan only provides coverage as required in the U.S.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
Home infusion therapy		
<p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
Hospice care		
<p>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in.</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 Lasso Healthcare MSA.</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 Lasso Healthcare MSA.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Hospice care (continued)</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 are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan, you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are not related to your terminal prognosis:</u> You pay your plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>		

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
 Immunizations Covered Medicare Part B services include: <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: <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 	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Inpatient hospital care (continued)</p> <p>Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Lasso Healthcare MSA provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</p> <ul style="list-style-type: none"> ● Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. The plan covers the first three (3) pints of blood and the deductible is waived. ● Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!”</p>		

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Inpatient hospital care (continued) This fact sheet is available on the Web at www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>		
<p>Inpatient mental health care Covered services include mental health care services that require a hospital stay. Restricted to 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul 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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies. • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. The plan covers the first three (3) pints of blood and the deductible is waived. <p>Other outpatient diagnostic tests</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Outpatient substance abuse services Covered services include Medicare-covered outpatient treatment of drug and alcohol rehabilitation.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your doctor, if your doctor orders it to see if you need medical treatment 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> • 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 receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers 		

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> • 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 • 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 prior to surgery <p>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>		

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 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 will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Services to treat kidney disease Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Skilled nursing facility (SNF) care (For a definition of “skilled nursing facility care,” see Chapter 10 of this document. Skilled nursing facilities are sometimes called “SNFs.”) Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three 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 • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.</p> <p>After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p>Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:</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>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
<p> Vision care Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

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

	Lasso Healthcare Growth (MSA)	Lasso Healthcare Growth Plus (MSA)
Services that are covered for you	What you must pay when you get these services	
 <p>“Welcome to Medicare” preventive visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <ul style="list-style-type: none"> • Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit. 	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>	<p>Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay \$0 for Medicare-covered services.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**SECTION 3 What services are not covered by the plan?****Section 3.1 Services we do *not* cover (exclusions)**

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<p style="text-align: center;">✓</p> <p>Available for people with chronic low back pain under certain circumstances.</p>
Cosmetic surgery or procedures		<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
<p>Custodial care.</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	<p>✓</p>	

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		<p style="text-align: center;">✓</p> <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		<p style="text-align: center;">✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
Orthopedic shoes or supportive devices for the feet		<p style="text-align: center;">✓</p> <p>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.</p>
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		<p style="text-align: center;">✓</p> <p>Covered only when medically necessary.</p>

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		✓ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

CHAPTER 5:

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

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

SECTION 1 Situations in which you should send us a bill you have received for your covered services

When you receive care, you should ask the provider to bill the plan for your services. We will look at the bill and decide whether the services should be covered and will let you know who should pay for them.

If you receive a bill for an item or services, you should send the bill to us. Here are some situations in which you should send a bill to us:

1. When you get a bill for an item or services even though you haven't yet met your deductible

Before you reach your deductible, you must pay the full cost of your covered services. Even though you are responsible for the cost, you should still send the bill to us before you pay it so we can make sure you have been billed the correct amount. After you pay a bill, you should send us a copy of the bill and your payment so that we can count your expenses towards your deductible.

2. When you get a bill for an item or services after you have met your deductible

After you meet the deductible, the plan will pay for your covered services. If you receive a bill, you should not pay it – you should submit it with a payment request to us. We will look at the bill and decide whether the services should be covered. If we decide they should be covered and you have not paid the bill, we will pay the provider directly. If we decide they should be covered and you have already paid the bill, we will mail you your reimbursement.

- After you meet your deductible, you don't have to pay anything for services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

3. If you are retroactively enrolled in our plan

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

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

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

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 document.)

When you send us a request for payment (or a request to count your expenses toward your deductible), we are making a “coverage decision.” This means that if we deny your request, you can appeal our decision. Chapter 7 of this document (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay a bill or to count your expenses toward your deductible

Section 2.1	How and where to send us your request
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When you want us to pay a bill or to pay you back for a bill you have already paid, send us a request for payment, along with your bill and documentation of any payment you have made. Even if you haven't met your deductible for the year, you should still send us your bill and documentation of your payment so we can count your expenses toward your deductible. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.lassohealthcare.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this document.)

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

Lasso Healthcare MSA
225 West Washington Street
Suite 450
Chicago, IL 60606

You must submit your claim to us within 1 year of the date you received the service, item, or drug.

Contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Chapter 5 Asking us to pay our share of a bill you have received for covered medical services**SECTION 3 We will consider your request and say yes or no****Section 3.1 We check to see whether we should cover the service and how much we owe**

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost.
 - If you have met your yearly deductible and have already paid for the service, we will mail your reimbursement to you.
 - If you have met your yearly deductible and have *not* paid for the service yet, we will mail the payment directly to the provider.
 - If you haven't met your deductible yet, we will tell you how much you should be billed by the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment or when we turned down your request to count medical expenses you have paid (either with money from your MSA account or out-of-pocket) toward the plan deductible. You may also appeal if you believe that, prior to meeting the deductible, you have been required to pay more for a service than the Medicare allowable amount.

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

CHAPTER 6:

Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)
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Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

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

Section 1.1	Debemos proporcionar información de una manera que funcione para usted y de acuerdo con sus sensibilidades culturales (en idiomas que no sean inglés, en braille, en letra grande u otros formatos alternativos, etc.)
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Para que le brindemos información en un formato que sea adecuado para usted, llame a Servicios para miembros (los números de teléfono aparecen en el reverso de este folleto).

Nuestro plan cuenta con servicios gratuitos de intérpretes que están disponibles para responder las preguntas de los miembros con discapacidades o que no hablan inglés. De ser necesario,

Chapter 6 Your rights and responsibilities

también podemos proporcionarle información en braille, en letra grande o en otros formatos alternativos sin costo alguno. Debemos proporcionarle información sobre los beneficios de su plan en un formato que sea accesible y adecuado para usted. Para obtener información en un formato que sea adecuado para usted, llame a Servicios para miembros (los números de teléfono aparecen en el reverso de este folleto).

Si tiene problemas para obtener información sobre nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja formal ante el Departamento de Apelaciones y Quejas Formales. También puede presentar una reclamación ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o, directamente, ante la Oficina de Derechos Civiles. La información de contacto se incluye en esta Evidencia de cobertura o en este correo o bien se puede comunicar con Servicios para miembros para obtener información adicional.

Section 1.2	We must ensure that you get timely access to your covered services
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You may seek care from any provider in the United States who is eligible to provide services under Original Medicare. You should always (except possibly in emergencies) show the provider your MSA plan membership card.

You do not need a referral or prior approval from the plan to receive covered services.

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

Section 1.3	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*

Chapter 6 Your rights and responsibilities

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

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

Section 1.4	We must give you information about the plan and your covered services
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[Plans may edit the section to reflect the types of alternate format materials available to plan members and/or language primarily spoken in the plan service area.]

As a member of Lasso Healthcare MSA, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical

service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

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

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

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

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

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

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

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

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

Chapter 6 Your rights and responsibilities

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency (such as the State Department of Health).

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

- You can **call Member Services**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Member Services**.
- You can **call the SHIP**, go to Chapter 2, Section 3.
- You can contact **Medicare**.

You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

Chapter 6 Your rights and responsibilities

- To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
 - Until you meet your yearly deductible, you must pay up to 100% of the Medicare-approved amount for your covered Part A and Part B services.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move outside of our plan service area, you generally cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Section 2.2	Special tax-reporting responsibilities of members of a Medicare MSA plan
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Our plan is a Medicare MSA plan. MSA members must file Form 1040, U.S. Individual Income Tax Return, along with Form 8853, "Archer MSAs and Long-Term Care (LTC) Insurance Contracts," to the Internal Revenue Service (IRS) for any year that distributions are made from their Medicare MSA account to ensure that they are not taxed on their MSA account withdrawals.

These tax forms must be filed for any year in which a MSA account withdrawal is made even if the member has no taxable income or any other reason for filing Form 1040. MSA account withdrawals for qualified medical expenses are tax-free, while account withdrawals for non-medical expenses are subject to both income tax and a 50% tax penalty.

- You will receive a statement (Form 1099-SA) from your MSA trustee reporting your MSA savings account distributions by January 31 each year. The trustee is also required to report this information to the IRS.
 - You must file tax forms 1040 and 8853 even if you are not otherwise required to file an income tax return in order to avoid owing taxes on MSA account withdrawals.

Chapter 6 Your rights and responsibilities

- Form 8853, “Archer MSAs and Long-Term Care (LTC) Insurance Contracts,” Section B, is the place to report both your Medicare MSA account withdrawals (which the IRS calls distributions) and on your qualified medical expenses for the year.
- Form 8853 and Form 8853 Instructions are available at www.irs.gov or from 1-800-TAX-FORM (1-800-829-3676). On the Web, look up forms by number at “Forms”. (**Note:** IRS tax code considers Medicare MSAs as a type of “Archer” MSA, therefore, IRS references to “Archer” MSAs include Medicare MSAs.)
- You must file by April 15 of the following year, unless you request an extension on your tax return.

Information reported to the IRS on MSA account withdrawals for qualified medical expenses is **not** the same expense information that will count towards your MSA plan deductible. Only Medicare Part A and Part B expenses will count towards your MSA plan deductible. Therefore, you will also want to keep track of your qualified medical expenses that are also Part A and Part B expenses and that will count towards your MSA plan deductible.

Helpful MSA-related publications related to tax-reporting requirements

The following are two IRS publications relevant to Medicare MSAs. They are available on the Web at www.irs.gov or from 1-800-TAX-FORM (1-800 829-3676). On the Web, look up publications by number at “Publications”.

- IRS Publication 502 (“Medical and Dental Expenses”) defines what types of services generally count as qualified medical expenses for IRS tax purposes.
- IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”) includes information on medical savings accounts, including Medicare MSAs. Publication 969 provides more items and services (in addition to those in Publication 502) that are qualified medical expenses for MSAs.

Who to call for more information or for help in preparing your tax return

You may call the IRS toll-free for live telephone assistance from Monday – Friday, 7 am – 10 pm local time, or you may visit your local IRS office.

- For individuals: 1-800-829-1040
- For people with hearing impairments: 1-800-829-4059 (TDD)

Face-to-Face Assistance: In certain areas, IRS also has local offices. Find your local office at www.irs.gov/help/contact-your-local-irs-office on the Web.

CHAPTER 7:

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

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**State Health Insurance Assistance Program (SHIP).**

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS**SECTION 4 A guide to the basics of coverage decisions and appeals****Section 4.1 Asking for coverage decisions and making appeals: the big picture**

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

Asking for coverage decisions prior to receiving services

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

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

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

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or “fast appeal” of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**

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

- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint”. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint”. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.

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

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

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

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

Section 5.3	Step-by-step: How to make a Level 1 appeal
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Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
A “fast appeal” is also called an “expedited reconsideration.”

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

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

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

Step 2: Ask our plan for an appeal or a fast appeal

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

Chapter 7 What to do 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 of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a “fast appeal”

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

Deadlines for a “standard” appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days to make the decision, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint”. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent

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

review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

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

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

Legal Term

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

- For the “standard appeal” if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug,

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the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

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

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

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

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

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

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

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?**

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

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

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

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

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

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

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

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
- 2. You will be asked to sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
- 3. Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
 - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date**

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

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

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

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

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

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

Act quickly:

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

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in

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

detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3	Step-by-step: How to make a Level 2 appeal to change your hospital discharge date
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

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

- **If we say no to your appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

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

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

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

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

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

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

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

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

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

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

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

Section 7.1	This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

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

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

<p>“Notice of Medicare Non-Coverage.” It tells you how you can request a “fast-track appeal.” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.</p>
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1. **You receive a notice in writing.** at least two days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.

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

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

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

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

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

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

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

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time**

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

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

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

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

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

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the review organization says yes?***

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written

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

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

You can appeal to us instead

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

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

Legal Term

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 3: If the Independent Review Organization say no your appeal, you choose whether you want to take your appeal further.

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at

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Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council’s decision.
- If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> ● Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> ● Did someone not respect your right to privacy or shared confidential information?

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Complaint	Example
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 are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services, that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the Independent Review Organization; you can make a complaint.

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Section 9.2 How to make a complaint

Legal Terms

- A “**Complaint**” is also called a “**grievance.**”
- “**Making a complaint**” is also called “**filing a grievance.**”
- “**Using the process for complaints**” is also called “**using the process for filing a grievance.**”
- A “**fast complaint**” is also called an “**expedited grievance.**”

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Grievance Filing Instructions**
When filing a written grievance, please provide:
 - Name
 - Address
 - Telephone Number
 - Member Identification Number
 - A summary of your complaint and when it happened.
 - A signature from you or your authorized representative and the date.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, Call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at: <https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>) and on our website at www.lassohealthcare.com).
 - This form gives that person permission to act on your behalf. It must be signed by you and the person who you would like to act on your behalf. You must give us a copy of the signed form.

Complaints about Medical Care

- File a verbal grievance by calling Member Services at 1-833-925-2776
- Send a written grievance to:

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Lasso Healthcare
 Appeals and Grievance Department
 PO Box 1222
 Chicago, IL 60606-1222
 Fax: 1-800-419-6475

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

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

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

Section 9.4	You can also make complaints about quality of care to the Quality Improvement Organization
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When your complaint is about *quality of care*, you also have two extra options:

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

OR

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

Section 9.5	You can also tell Medicare about your complaint
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You can submit a complaint about Lasso Healthcare MSA directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Lasso Healthcare MSA may be **voluntary** (your own choice under permitted situations) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 6 tells you about situations when we must end your membership.

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

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

Section 2.1	You can end your membership during the Annual Enrollment Period
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You can end your membership in our plan during the **Annual Enrollment Period** (also known as the “Annual Open Enrollment Period”). In certain situations, you may also be eligible to leave the plan at other times of the year. If this is your first time enrolling in an MSA plan you may cancel this enrollment by December 15, 2022.

- **The Annual Enrollment Period** is from October 15 to December 7.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Keep your Medicare Savings Account (MSA) plan and enroll in a separate prescription drug plan (or enroll in a new prescription drug plan if you do not currently have one);
 - Another Medicare health plan, with or without prescription drug coverage
 - Original Medicare *with* a separate Medicare prescription drug plan;

OR

 - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

Section 2.2	In certain limited situations, you can end your membership during a Special Enrollment Period
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In certain limited situations, members of Lasso Healthcare MSA may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you have moved.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- If you have a change in your Medicaid status. (Please note that people with Medicaid coverage are not eligible to enroll in a Medicare MSA plan.)

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage you can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan (or enroll in a new prescription drug plan if you do not currently have one).

OR

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

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

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.3	Where can you get more information about when you can end your membership?
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If you have any questions about ending your membership you can:

- **Call Member Services.**

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

SECTION 3 What happens if you leave our plan in the middle of the year?

Section 3.1 What happens to the money in your account if you leave our plan?
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If you leave our plan in the middle of the year, part of the current year’s deposit will be refunded to Medicare. The amount recovered and refunded to Medicare depends on the number of months left in the current calendar year. For example, if you get a \$1,200 deposit in your account in January and you leave the plan in March, we will recover \$900 to return to Medicare.

Funds remaining in your account from any previous year belong to you. Recovery applies only to funds deposited into your account for the current year. If you have any questions, please contact Member Services.

SECTION 4 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none">• Another Medicare health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare health plan. You will automatically be disenrolled from Lasso Healthcare MSA when your new plan’s coverage begins.
<ul style="list-style-type: none">• Original Medicare (either with or without a separate Medicare prescription drug plan).	<ul style="list-style-type: none">• Send us a written request to disenroll Contact Member Services if you need more information on how to do this.• You will be disenrolled from Lasso Healthcare MSA when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare

drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 5 Until your membership ends, you must keep getting your medical services and drugs through our plan

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

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

SECTION 6 Lasso Healthcare MSA must end your membership in the plan in certain situations

Section 6.1 When must we end your membership in the plan?

Lasso Healthcare MSA must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you obtain other insurance (to include supplemental policies) that covers all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, or retirement health benefits.
- If you move out of our service area.
- If you are away from our service area for more than six months.
- If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

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

Where can you get more information?

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

Section 6.2	We <u>cannot</u> ask you to leave our plan for any health-related reason
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Lasso Healthcare MSA is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 6.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint (also called a grievance) about our decision to end your membership; see Chapter 7 for how to file a complaint.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

If you have a disability and need help with access to care, please call us at Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Lasso Healthcare Notice of Non-Discrimination **Discrimination is against the law.**

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

Lasso Healthcare:

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

Chapter 9 Legal notices

If you need these services, contact Member Services at 1-833-925-2776 (TTY 711).

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

Lasso Healthcare
Civil Rights Coordinator
225 W. Washington Street, Suite 450
Chicago, Illinois 60606
Phone: 1-833-925-2776, TTY number 711
Fax: 1-866-946-4458
Email: civilrightscoordinator@myzinghealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Lasso Healthcare Civil Rights Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Chapter 9 Legal notices**Multi-language Interpreter Services**

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-925-2776 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-925-2776 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-925-2776 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-925-2776 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-925-2776. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-925-2776 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-925-2776 (TTY: 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-925-2776 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-925-2776 (TTY: 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-925-2776 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Chapter 9 Legal notices

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على . سيقوم شخص ما يتحدث العربية.(TTY: 711) 1-833-925-2776 مترجم فوري، ليس عليك سوى الاتصال بنا على . بمساعدتك. هذه خدمة مجانية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-925-2776 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-925-2776 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-925-2776 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-925-2776 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-833-925-2776 (TTY: 711) にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Lasso Healthcare MSA, 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 9 Legal notices**Share your information with third-party applications**

You can ask us to share your health information with third-party applications on your phone, tablet, or computer.

Within 24 hours of receiving your request, we will allow a third-party application to access your health information via a Patient Access Application Programming Interface (“API”) that we securely maintain.

You should be informed of privacy considerations before agreeing to share your health information with a third-party application. See our **Guide to Sharing Information with Third-party Applications (PDF)** to learn how to safely share your information.

Lasso Healthcare will request that third-party applications attest to important privacy and security practices. When you request a third-party application to have access to your data, we will share the third-party applications’ attestation status with you to help you make informed decisions prior to sharing your health information.

If you have chosen to share your health information with a third-party application via the Lasso Healthcare Patient Access API in the past, and no longer wish to allow the third-party application to continue to access your health information, you should contact the third-party application directly.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1.

If you believe Lasso Healthcare or another covered entity has violated the HIPAA Privacy Rule, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

If you believe a third-party application has violated their privacy policy regarding your health information, you can file a complaint with the Federation Trade Commission by using the online FTC Complaint Assistant at <https://reportfraud.ftc.gov/#/?pid=B>.

We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in payment for your care

Share information in a disaster relief situation

Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

Marketing purposes

Chapter 9 Legal notices

Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

Preventing disease

Helping with product recalls

Reporting adverse reactions to medications

Reporting suspected abuse, neglect, or domestic violence

Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Chapter 9 Legal notices**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

We can share health information about you with organ procurement organizations.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

For workers' compensation claims

For law enforcement purposes or with a law enforcement official

With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not limit your information sharing with third-party applications unless we have determined that allowing an application to connect or remain connected to our Patient Access API would present an unacceptable level of risk to the security of our members' protected health information (PHI) within our systems.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

CHAPTER 10:

Definitions of important words

Chapter 10 Definitions of important words

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

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan’s allowed cost-sharing amount. As a member of Lasso Healthcare MSA, you only have to pay our plan’s cost-sharing amounts when you get services covered by our plan. We do not allow providers to “balance bill” or otherwise charge you more than the amount of cost sharing your plan says you must pay.

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

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

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

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

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed

Chapter 10 Definitions of important words

“copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

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

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

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.

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

Chapter 10 Definitions of important words

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

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

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

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

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

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

Maximum Out-of-Pocket Amount (MOOP) – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid. You cannot be a member of our Medicare Medical Savings Account (MSA) plan if you have 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 (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing

Chapter 10 Definitions of important words

from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

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

Medicare Medical Savings Account (MSA) Plan – A type of Medicare Advantage Plan that combines a high-deductible health insurance plan with a medical savings account that members can use to pay for their health care costs.

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

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

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

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

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.

Chapter 10 Definitions of important words

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

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

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

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Prior Authorization – Approval in advance to get services. As a member of a Medicare Medical Savings Account (MSA) plan, you do not need prior authorization to obtain services. However, you may want to check with us before obtaining services to confirm that the service is covered by the plan.

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

Qualified Medical Expenses - Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction on your income tax return. These expenses are explained in IRS Publication 502, Medical and Dental Expenses.

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.

Chapter 10 Definitions of important words

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

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

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

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

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

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

Lasso Healthcare MSA Member Services

Method	Member Services – Contact Information
CALL	1-833-925-2776 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Available 8 a.m. to 8 p.m., seven days a week from October 1 through March 31, and Monday – Friday from April 1 through September 30.
FAX	1-855-329-5276
WRITE	Lasso Healthcare MSA 225 West Washington St. Suite 450 Chicago, IL 60606
WEBSITE	www.lassohealthcare.com

State Health Insurance Assistance Program (SHIP)

State Health Insurance Program, or SHIP, is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You will find your state's SHIP phone number in Chapter 2, Section 3 of this document.

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