January 1 – December 31, 2022

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of UW Health IL Quartz Medicare Advantage an HMO plan with a Medicare contract

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2022. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

This plan, UW Health IL Quartz Medicare Advantage, is offered by Quartz Medicare Advantage. (When this Evidence of Coverage says "we," "us," or "our," it means Quartz Medicare Advantage. When it says "plan" or "our plan," it means UW Health IL Quartz Medicare Advantage.

If you have questions or require language assistance, please call Customer Service at (800) 394-5566. For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Interpreter services are provided free of charge to you. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. You can also visit our website at QuartzBenefits.com/MedicareAdvantage.

If you would like an appointment with a member of our Customer Service team, we are available upon request. For more information on scheduling, please call (800) 394-5566.

We can also give you information in large print or other alternate formats.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

H5262_21 177_C File & Use 09152021

GH00370SAHS (0821) OMB Approval 0938-1051 (Expires: February 29, 2024)

2022 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member 4

Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources 16

Tells you how to get in touch with our plan (UW Health IL Quartz Medicare Advantage) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your medical services 30

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.

Chapter 4. Medical Benefits Chart (what is covered and what you pay) 46

Gives the details about which types of medical care are covered and *not* covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services 138

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.

Chapter 6. Your rights and responsibilities 144

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) 155

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care you think is covered by our plan. This includes asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 8. Ending your membership in the plan 197

Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 9. Legal notices 205

Includes notices about governing law and about nondiscrimination.

Chapter 10. Definitions of important words 211

Explains key terms used in this booklet.

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction 5
Section 1.1 You are enrolled in UW Health IL Quartz Medicare Advantage, which is a Medicare HMO 5
Section 1.2 What is the *Evidence of Coverage* booklet about? 5
Section 1.3 Legal information about the *Evidence of Coverage* 5

SECTION 2 What makes you eligible to be a plan member? 6
Section 2.1 Your eligibility requirements 6
Section 2.2 What are Medicare Part A and Medicare Part B? 6
Section 2.3 Here is the plan service area for UW Health IL Quartz Medicare Advantage 6
Section 2.4 U.S. Citizen or Lawful Presence 7

SECTION 3 What other materials will you get from us? 7
Section 3.1 Your plan membership card – Use it to get all covered care 7
Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network 8

SECTION 4 Your monthly premium for UW Health IL Quartz Medicare Advantage 9
Section 4.1 How much is your plan premium? 9
Section 4.2 There are several ways you can pay your plan premium 10
Section 4.3 Can we change your monthly plan premium during the year? 12

SECTION 5 Please keep your plan membership record up to date 12
Section 5.1 How to help make sure that we have accurate information about you 12

SECTION 6 We protect the privacy of your personal health information 13
Section 6.1 We make sure that your health information is protected 13

SECTION 7 How other insurance works with our plan 13
Section 7.1 Which plan pays first when you have other insurance? 13

SECTION 1 Introduction

Section 1.1 You are enrolled in UW Health IL Quartz Medicare Advantage, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, UW Health IL Quartz Medicare Advantage.

There are different types of Medicare health plans. UW Health IL Quartz Medicare Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. UW Health IL Quartz Medicare Advantage does not include Part D prescription drug coverage.

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

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

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

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of UW Health IL Quartz Medicare Advantage.

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in UW Health IL Quartz Medicare Advantage between January 1, 2022 and December 31, 2022.

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 UW Health IL Quartz Medicare Advantage after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States

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

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

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

Section 2.3 Here is the plan service area for UW Health IL Quartz Medicare Advantage

Although Medicare is a Federal program, UW Health IL Quartz Medicare Advantage is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below:

Our service area includes these counties in Illinois: Boone, Carroll, Jo Daviess, Lee, Ogle, Stephenson, and Winnebago.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). 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.

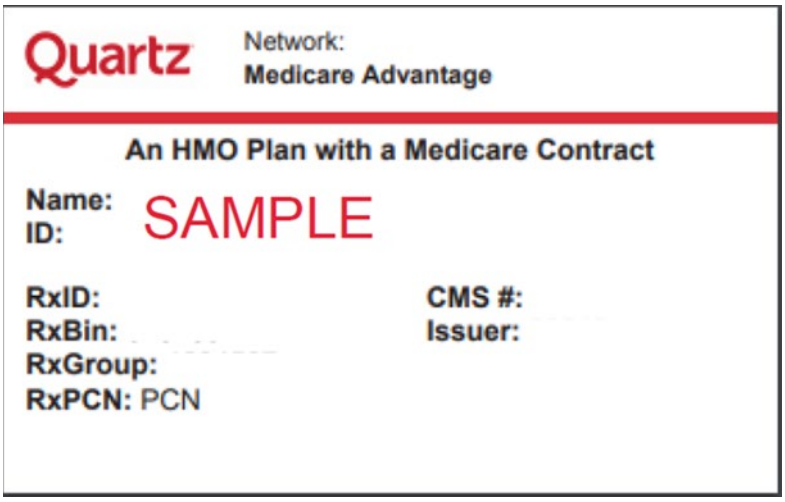
Section 2.4 U.S. Citizen or Lawful Presence

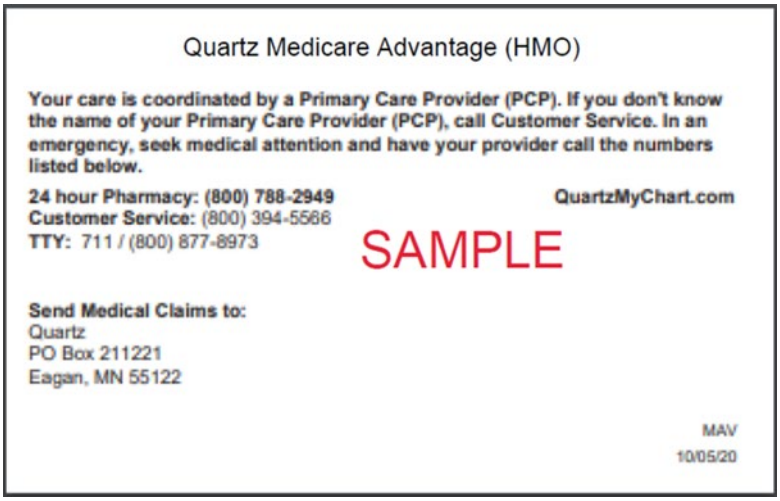
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UW Health IL Quartz Medicare Advantage if you are not eligible to remain a member on this basis. UW Health IL Quartz Medicare Advantage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

SECTION 3 What other materials will you get from us?

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

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




Quartz Medicare Advantage (HMO)

Your care is coordinated by a Primary Care Provider (PCP). If you don't know the name of your Primary Care Provider (PCP), call Customer Service. In an emergency, seek medical attention and have your provider call the numbers listed below.

24 hour Pharmacy: (800) 788-2949
Customer Service: (800) 394-5566
TTY: 711 / (800) 877-8973

QuartzMyChart.com

SAMPLE

Send Medical Claims to:
Quartz
PO Box 211221
Eagan, MN 55122

MAV
10/05/20

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 UW Health IL Quartz Medicare Advantage 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 routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your UW Health IL Quartz Medicare Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

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

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers, network pharmacies, and durable medical equipment suppliers.

What are "network providers"?

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

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which UW Health IL Quartz Medicare Advantage authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at QuartzBenefits.com/MedicareAdvantage, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for UW Health IL Quartz Medicare Advantage

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each plan we are offering in the service area.

Plan Name	Monthly Plan Premium
Quartz Medicare Advantage Value	$0
Quartz Medicare Advantage Elite	$30

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

In some situations, your plan premium could be <u>more</u>

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call **Customer Service** (phone numbers are printed on the back cover of this booklet). **The premium amount for the Quartz Medicare Advantage Optional Dental Rider is $48.10.**

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, 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 premiums to remain a member of the plan.**

Your copy of the *Medicare & You 2022* handbook gives information about these premiums in the section called "2022 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 2022* 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 2022* 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 4.2 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check or money order (cash not accepted)

If you choose to pay your monthly premium payment by check or money order, you will receive monthly invoices approximately 15 days prior to the invoice due date.

Premium payments should be sent using the remittance located at the bottom of the monthly invoice. Premium payments should be sent to the following address:

Quartz Medicare Advantage - MN
PO Box 78498
Milwaukee, Wisconsin 53278-8498

Option 2: Automatic recurring electronic payment from bank account or credit card

If you choose to have Quartz process your monthly premium via automatic payment withdrawal from your banking account, it will take effect approximately 30 days after we have received your written request or Payment Change Form to put this in place. We will send you written notification stating the month that your automatic payment will begin. These automatic withdrawals will occur on the 4th business day of every month.

You are also able to set up automatic payments yourself through your Quartz MyChart account for either bank account withdrawals or credit card payments. You can select the day of the month you would like your premium paid, and it will be effective immediately. This information can be changed at any time. If you switch to this self-service method, please be sure to cancel your existing Quartz automatic payment withdrawal. Contact Customer Service for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet)

Option 3: One-time electronic payment from bank account or credit card

If you choose to pay your monthly premium via one-time electronic payment from your bank account or credit card, you can do so yourself through your Quartz MyChart account. You can select the day you would like your premium paid, and it will be processed on that date. You will also receive an electronic confirmation of your payment.

Contact Customer Service for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Option 4: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the 1st. If we have not received your premium by the 15th, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within two calendar months of the original due date.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premiums, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of these premiums. In the future, if you want to enroll again in

our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling Customer Service at (800) 394-5566 between Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. TTY/TDD users should call 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Interpreter services are provided free of charge to you. You must make your request no later than 60 days after the date your membership ends.

Section 4.3 Can we change your monthly plan premium during the year?

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

SECTION 5 Please keep your plan membership record up to date

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

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

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

Let us know about these changes:

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

- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

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.

Read over the information we send you about any other insurance coverage you have

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 **UW Health IL Quartz Medicare Advantage contacts** (how to contact us, including how to reach Customer Service at the plan) **17**

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program) **22**

SECTION 3 **State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare) **23**

SECTION 4 **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare) **24**

SECTION 5 **Social Security** **25**

SECTION 6 **Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources) **26**

SECTION 7 **How to contact the Railroad Retirement Board** **27**

SECTION 8 **Do you have "group insurance" or other health insurance from an employer?** **28**

SECTION 1 UW Health IL Quartz Medicare Advantage contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to UW Health IL Quartz Medicare Advantage Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	(800) 394-5566 Calls to this number are free. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. If you are calling outside of our normal office hours, you can leave a confidential voicemail message and your call will be returned on the next business day. If you would like an appointment with a member of our Customer Service team, we are available upon request. For more information on scheduling, please call (800) 394-5566. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 643-2564, Attention: Customer Service
WRITE	Quartz Medicare Advantage Attention: Customer Service 840 Carolina Street Sauk City, Wisconsin 53583 Email: CustomerService@QuartzBenefits.com Secure Member Portal: QuartzMyChart.com

Method	Customer Service – Contact Information
WEBSITE	QuartzBenefits.com/MedicareAdvantage

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

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	(800) 394-5566 Calls to this number are free. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. If you are calling outside of our normal office hours, you can leave a confidential voicemail message and your call will be returned on the next business day.
TTY/TDD	For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 881-8397 Attention: Medical Management Or for clinically administered drugs (i.e. infusions) (608) 881-8398 Attention Pharmacy Management

Method	Coverage Decisions for Medical Care – Contact Information
WRITE	Quartz Medicare Advantage Attention: Medical Management or Pharmacy Management 840 Carolina Street Sauk City, Wisconsin 53583
WEBSITE	QuartzBenefits.com/MedicareAdvantage

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Medical Care – Contact Information
CALL	(800) 394-5566, Ext. 308284 to reach an Appeals Specialist. Appeals Specialists can be reached Monday through Friday from 8:00 a.m. to 4:30 p.m. Calls to this number are free. If you would like an appointment with a member of our Appeals team, we are available upon request. Please call to schedule an appointment.
TTY/TDD	For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 644-3500, Attention: Appeals Specialists
WRITE	Quartz Medicare Advantage Attention: Appeals Specialists 840 Carolina Street Sauk City, Wisconsin 53583 Email: AppealsSpecialists@QuartzBenefits.com
WEBSITE	QuartzBenefits.com/MedicareAdvantage

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) 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	(800) 394-5566 Calls to this number are free. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. If you are calling outside of our normal office hours, you can leave a confidential voicemail message and your call will be returned on the next business day.
TTY/TDD	For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 644-3500, Attention: Appeals Specialists
WRITE	Quartz Medicare Advantage Attention: Appeals Specialists 840 Carolina Street Sauk City, Wisconsin 53583 Email: AppealsSpecialists@QuartzBenefits.com
MEDICARE WEBSITE	You can submit a complaint about UW Health IL Quartz Medicare Advantage directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information
CALL	(800) 394-5566 Calls to this number are free.
TTY/TDD	For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 643-2564 Attention: Claims Dept.
WRITE	For MEDICAL claims: Quartz Medicare Advantage Attention: Claims Dept. 840 Carolina Street Sauk City, Wisconsin 53583
WEBSITE	QuartzBenefits.com/MedicareAdvantage

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (CONTINUED)	You can also use the website to tell Medicare about any complaints you have about UW Health IL Quartz Medicare Advantage: • **Tell Medicare about your complaint:** You can submit a complaint about UW Health IL Quartz Medicare Advantage 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. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

Senior Health Insurance Program Illinois counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior Health Insurance Program Illinois counselors can also 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 "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
  - Option #1: You can have a **live chat**
  - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
  - Option #3: 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	Senior Health Insurance Program - Illinois (SHIP) – Contact Information
CALL	(800) 252-8966
TTY	(888) 206-1327
WRITE	Illinois Department on Aging One Natural Resources Way, #100 Springfield, Illinois 62702-1271 Email: AGING.SHIP@illinois.gov
WEBSITE	Illinois.gov/aging/ship

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state.

For Illinois, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality

of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

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

Method	Livanta (Illinois' Quality Improvement Organization) – Contact Information
CALL	(888) 524-9900
TTY	(888) 985-8775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	10820 Guilford Road, Suite 202 Annapolis Junction, Maryland 20701 Fax: (855) 236-2423
WEBSITE	livantaqio.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 7:00 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 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **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 Illinois Department of Health Services.

Method	Illinois Department of Health Services (Medicaid program) – Contact Information
CALL	(800) 843-6154 Staff are available 8:00 am – 5:00 pm, Monday through Friday with the exception of state holidays.
TTY	(866) 324-5553 or 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Illinois Department of Health Services 100 South Grand Avenue East Springfield, Illinois 62762
WEBSITE	www.dhs.state.il.us

SECTION 7 How to contact the Railroad Retirement Board

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

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

Method	Railroad Retirement Board – Contact Information
CALL	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 *not* free.
WEBSITE	rrb.gov/

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

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

CHAPTER 3

Using the plan's coverage for your medical services

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

SECTION 1 Things to know about getting your medical care covered as a member of our plan ... 32

Section 1.1 What are "network providers" and "covered services"? ... 32

Section 1.2 Basic rules for getting your medical care covered by the plan ... 32

SECTION 2 Use providers in the plan's network to get your medical care ... 33

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care ... 33

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP? ... 34

Section 2.3 How to get care from specialists and other network providers ... 34

Section 2.4 How to get care from out-of-network providers ... 36

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster ... 36

Section 3.1 Getting care if you have a medical emergency ... 36

Section 3.2 Getting care when you have an urgent need for services ... 38

Section 3.3 Getting care during a disaster ... 38

SECTION 4 What if you are billed directly for the full cost of your covered services? ... 39

Section 4.1 You can ask us to pay our share of the cost of covered services ... 39

Section 4.2 If services are not covered by our plan, you must pay the full cost ... 39

SECTION 5 How are your medical services covered when you are in a "clinical research study"? ... 39

Section 5.1 What is a "clinical research study"? ... 39

Section 5.2 When you participate in a clinical research study, who pays for what? ... 40

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution" ... 41

Section 6.1 What is a religious non-medical health care institution? ... 41

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution ... 42

SECTION 7 Rules for ownership of durable medical equipment ... 42

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan? ... 42

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance 43
Section 8.1 What oxygen benefits are you entitled to? 43
Section 8.2 What is your cost sharing? Will it change after 36 months?..... 43
Section 8.3 What happens if you leave your plan and return to Original Medicare? 44

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

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

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

Section 1.1 What are "network providers" and "covered services"?

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

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

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

As a Medicare health plan, UW Health IL Quartz Medicare Advantage must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

UW Health IL Quartz Medicare Advantage will generally cover your medical care as long as:

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

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network primary care provider (PCP) must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
    - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. A written referral must be approved by the plan's medical director prior to seeking care if your network provider suggests or recommends care out-of-network. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

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

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

Your "primary care provider (PCP)" is a practitioner who meets state requirements and is trained to give you basic medical care. When you become a member of our Plan, you must choose a plan provider to be your primary care provider (PCP). As we explain below, you will get your routine or basic care from your primary care provider (PCP). Your "primary care provider (PCP)" will also monitor the rest of the covered services you get as a plan member. You do not need a

referral from your primary care provider (PCP) to see an in-network specialist; however, reports from specialists will be sent to your primary care provider (PCP) to better help coordinate your care.

How do you choose your PCP?

When you enrolled in the plan, you may have selected your primary care provider (PCP) from our *Provider Directory* or if you have not and would like assistance in selecting one, you may call UW Health IL Health Connect Department at (779) 696-7081.

Changing your PCP

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

For assistance in changing your primary care provider (PCP), you may call UW Health IL Health Connect Department at (779) 696-7081.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and COVID-19 vaccinations.
- Pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

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

- Oncologists care for patients with cancer.

- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.
- Behavioral Health Specialists care for patients with mental health conditions, alcohol, and other drug addictions.

We do not require a referral from your primary care provider (PCP) to see an in-network specialist.

- All UW Health IL Quartz Medicare Advantage members will have direct access to UW Health IL Quartz Medicare Advantage participating practitioners and providers, including specialists. Referrals are not required between UW Health IL Quartz Medicare Advantage participating practitioners/providers. It is expected that the primary care provider (PCP) will be identified before or at the time of member appointment, and communication will occur between UW Health IL Quartz Medicare Advantage practitioners/providers in an effort to provide coordinated quality, cost-effective care for all UW Health IL Quartz Medicare Advantage members.

Providers are required to assist UW Health IL Quartz Medicare Advantage members in obtaining prior authorization.

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

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

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

If you have questions or require language assistance, please call Customer Service at (800) 394-5566. For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Interpreter services are provided free of charge to you. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. You can also visit our website at QuartzBenefits.com/MedicareAdvantage.

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

In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are four exceptions:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. A written referral must be approved by the plan's medical director prior to seeking care if your network provider suggests or recommends care out-of-network. In this situation, you will pay the same as you would pay if you got the care from a network provider.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- Travel Benefit that provides coverage for services received in other states with some exclusions (see Chapter 4, Section 2.3).

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at (800) 394-5566. For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Interpreter services are provided free of charge to you. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. You can also visit our website at QuartzBenefits.com/MedicareAdvantage.

What is covered if you have a medical emergency?

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

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

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

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

What are "urgently needed services"?

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

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

You should contact your primary care provider (PCP), the nearest hospital, urgent care center, or dial 911 to be directed to the nearest provider.

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

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

Our plan covers world-wide emergency care, urgently needed services and ambulance services outside of the U.S. and its territories in the same manner as within. Please see these sections in Chapter 4 for more information.

Section 3.3 Getting care during a disaster

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

Please visit the following website: https://www.medicare.gov/what-medicare-covers/getting-care-drugs-in-disasters-or-emergencies for information on how to obtain needed care during a disaster.

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

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

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

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

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

UW Health IL Quartz Medicare Advantage covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

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

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

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once the benefit limitation is reached, the full cost you pay does not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

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

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

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

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

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

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

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your

cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

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

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by 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 covered in a "religious non-medical health care institution"

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

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

Section 6.2 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 conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care;
    - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Refer to Chapter 4 Benefits Chart, Inpatient Hospital, for coverage limitations.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of UW Health IL Quartz Medicare Advantage, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service

(phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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. Payments you made while in our plan do not count toward these 13 consecutive payments.

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

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, UW Health IL Quartz Medicare Advantage 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 UW Health IL Quartz Medicare Advantage or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 20%, every month for the rental of the equipment for the first 36 months.

For the 24 months following the first 36 months (a total of 60 months), co-insurance is due for oxygen contents (when applicable) and for every instance of maintenance and service. Maintenance and service is allowed once every six months during the remaining 24 months.

At the end of this 60-month period, the DME supplier should give the member the option to get new equipment. If the member chooses to do so, the whole process starts over with a new 36-month equipment rental period followed by 24 months of contents and/or maintenance and service.

If prior to enrolling in UW Health IL Quartz Medicare Advantag*e* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in UW Health IL Quartz Medicare Advantage is 20% coinsurance.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining UW Health IL Quartz Medicare Advantage, join UW Health IL Quartz Medicare Advantage for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in UW Health IL Quartz Medicare Advantage and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

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 47

Section 1.1 Types of out-of-pocket costs you may pay for your covered services 47

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services? 47

Section 1.3 Our plan does not allow providers to "balance bill" you 48

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay 49

Section 2.1 Your medical benefits and costs as a member of the plan 49

Section 2.2 Extra "optional supplemental" benefits you can buy 121

Section 2.3 Getting care using our plan's optional visitor/traveler benefit 126

SECTION 3 What services are not covered by the plan? 127

Section 3.1 Services we do *not* cover (exclusions) 127

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of UW Health IL Quartz Medicare Advantage. Later in this chapter, you can find information about medical services that are not covered.

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

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

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

Value Members: As a member of UW Health IL Quartz Medicare Advantage, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2022 is $4,900. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $4,900, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and

the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Elite Members: As a member of UW Health IL Quartz Medicare Advantage, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2022 is $3,450. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3,450, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of UW Health IL Quartz Medicare Advantage (HMO), in partnership with UW Health IL, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

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

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

The Medical Benefits Chart on the following pages lists the services UW Health IL Quartz Medicare Advantage (HMO), in partnership with UW Health IL, covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in bold.

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 2022* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition. If, during this exam, labs or radiology is needed that are not considered preventative, a cost-share (like copayment or coinsurance) will apply.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

:

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

You will see this star next to benefits that our plan offers above Medicare covered services (supplemental).

Medical Benefits Chart

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance or copayment for members eligible for this preventive screening	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
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: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$20 copayment for up to 20 treatments per year $20 copayment for Medicare-covered services	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Acupuncture for chronic low back pain (continued) 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 acupuncture if they meet all applicable state requirements and have: • 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,		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Acupuncture for chronic low back pain (continued) • 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. 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.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. ★ Medically necessary emergency transport is covered world-wide.	$250 copayment each trip for Medicare-covered ambulance benefits	$225 copayment each trip for Medicare-covered ambulance benefits

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Annual wellness visit 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 calendar year. **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. Your wellness visit may include a periodic or routine health examination.	There is no coinsurance or copayment for the annual wellness visit. Discussion, evaluation, assessment, and treatment of any health condition during your visit is covered with no additional copayment.	
Brain Fitness BrainHQ has dozens of exercises that have been proven in multiple scientific studies to help members think faster, focus better, and remember more. To learn more and get started training your brain go to your Quartz MyChart account or go quartz.brainhq.com.	There is no copayment to access memory fitness programs.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Bone mass measurement 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.	There is no coinsurance or copayment for Medicare-covered bone mass measurement.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance or copayment for covered screening mammograms.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
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. No limit to the number of cardiac rehabilitation visits allowed based on medical necessity.	$20 copayment for each covered cardiac therapy visit	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance or copayment for cardiovascular disease testing that is covered once every 5 years.	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • For women aged 30 to 65 years: HPV testing once every five years in conjunction with the Pap smear test. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance or copayment for Medicare-covered preventive Pap and Pelvic Exams.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation ★ Examination/therapy ★ Lab and X-ray **Important:** Refer to your Provider Directory for a participating chiropractor. Coverage does not include preventive/maintenance therapy.	$20 copayment for each Medicare-covered visit $20 copayment for routine chiropractic examinations/therapy $10 copayment for lab per day $15 copayment for X-ray	$20 copayment for each Medicare-covered visit $20 copayment for routine chiropractic examinations/therapy $5 copayment for lab per day $10 copayment for X-ray

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA Based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.	$35 copayment for Medicare-covered dental exam	$25 copayment for Medicare-covered dental exam
We cover non-routine dental care such as 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. Services received from a dentist in an emergency situation are subject to plan rules and cost sharing.	$500 limit for combined preventative and comprehensive coverage	$700 limit for combined preventative and comprehensive coverage
★ Plan covers the following services: Oral Exams, Prophylaxis (Cleaning), Fluoride Treatment, Dental X-Rays, Non-routine Services, Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Dental services (continued) See Section 2.2 of this chapter for information about the Quartz Medicare Advantage Optional Dental Rider (optional supplemental benefits) for additional preventive and comprehensive dental coverage. **Important:** Amounts over fee schedule and annual limit are the responsibility of the member and don't apply to the maximum out of pocket. Visit a dental provider of your choice or call Customer Service for a listing of associated providers.		
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance or copayment for an annual depression screening visit.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these 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.	There is no coinsurance or copayment for the Medicare covered diabetes screening tests.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • 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. To obtain a free meter, ask your pharmacist or call Quartz Medicare Advantage Customer Service for assistance and details.	There is no coinsurance or copayment for each preferred covered diabetic testing supply item. Testing supplies are limited to plan's preferred manufacturer. If there is medical justification submitted and approved through prior authorization, other manufacturer testing supplies may be approved at no cost share. Blood glucose test strips limited to 200 strips per 30 days. A medical justification must be submitted and approved through prior authorization in order to exceed this limit. 20% coinsurance for therapeutic shoes and inserts There is no coinsurance or copayment for Medicare-covered diabetes self-management training preventive benefit	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 10 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. You may also use local pharmacies for certain DME items such as Therapeutic Continuous Glucose Monitors (CGMs). Call Quartz Medicare Advantage customer service for assistance and details.	**You must obtain prior authorization for purchases, repairs, and or rentals over $500** 20% coinsurance for Medicare-covered items	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ★ Emergency medical care is covered world-wide.	$90 copayment for Medicare-covered emergency room visits. If you are admitted to the hospital within three days for the same condition, the emergency room copayment would be waived. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
★ **Fitness Benefit** Plan provides Quartz® CashCard to make fitness membership payments. Swipe your card at any licensed fitness facility that provides membership programs. Any fitness center services that usually have an extra fee are not included in this benefit.* If for some reason you are unable to use your card, you can submit a reimbursement request via the card portal on your Quartz MyChart account. *Amounts over monthly limit do not apply toward out-of-pocket maximum	Up to $25 per month for fitness membership dues.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Hearing services 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. ★ One routine hearing exam ★ Hearing Aids **Important:** Please visit the plan's website or call Customer Service for a listing of participating hearing aid providers.	$35 copayment for each Medicare-covered hearing exam $35 copayment for routine hearing exams up to one test every calendar year	$25 copayment for each Medicare-covered hearing exam $25 copayment for routine hearing exams up to one test every calendar year

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Hearing services (continued) Plan covers up to two aids per year at select participating audiology providers. **Benefit does <u>not</u> include or cover any of the following:** • Ear mold replacements • Additional or rechargeable batteries • Hearing tests • Additional visits • Restocking fees • Replacement warranty costs • If device is lost **These may be available through the provider for an additional fee.**	$1000 plan maximum* *Amounts over the plan maximum do not apply to your out-of-pocket maximum. Costs associated with excluded items are the responsibility of the member and not covered by the plan.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**You must obtain prior authorization** There is no coinsurance or copayment for Medicare-covered services	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Home infusion therapy 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: • 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	**You must obtain prior authorization** 20% coinsurance for Medicare-covered items	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.	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 UW Health IL Quartz Medicare Advantage. See specific sections in the Medical Benefits Chart for copayments or coinsurance amounts that may apply.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Hospice care (continued) For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Hospice care (continued) For services that are covered by UW Health IL Quartz Medicare Advantage but are not covered by Medicare Part A or B: UW Health IL Quartz Medicare Advantage will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • 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 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules For help with understanding whether a vaccine is covered, please call Quartz Medicare Advantage Customer Service.	There is no coinsurance or copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these 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: • 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	Days 1-7: $275 copayment per day for Medicare-covered services Days 8- discharge: $0 copayment for additional hospital days ★ No limit to the number of days covered by the plan based on medical necessity	$325 copayment per admission for Medicare-covered services There is no coinsurance or copayment for additional hospital days ★ No limit to the number of days covered by the plan based on medical necessity

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. • If UW Health IL Quartz Medicare Advantage provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. ★ Blood - including storage and administration. Coverage of whole blood and packed red cells beginning with the first pint used • Physician services	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Inpatient hospital care (continued) **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at 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.		
Inpatient mental health care Covered services include mental health care services that require a hospital stay. ★ No limit to the number of days covered by the plan based on medical necessity.	Days 1-6: $275 copayment per day for Medicare-covered services Days 7- discharge: $0 copayment for additional hospital days	$325 copayment per admission for Medicare-covered services There is no coinsurance or copayment for additional hospital days

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay 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: • 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	See specific sections in the Medical Benefits Chart for copayments or coinsurance amounts that may apply.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued) • 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		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
★ **Massage therapy for chronic pain conditions** Services are covered for individuals with following chronic conditions: • Chronic Neck pain • Chronic Low Back pain • Osteoarthritis of the Knee • Cancer patients with pain • Fibromyalgia • Myofascial pain syndrome • Diabetes (Type 2) with Peripheral Neuropathy Patients must have a doctor's order indicating one of these conditions for coverage of massage therapy. **Important:** Refer to your *Provider Directory* for a participating massage therapist.	$20 copayment for each visit Limited to 12 massage visits per year, each visit up to 60 minutes	There is no coinsurance or copayment for each visit Limited to 12 massage visits per year, each visit up to 60 minutes

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Meal Delivery After your inpatient stay in the hospital or Skilled Nursing Facility (SNF)/Swing Bed stay, you are eligible to receive 2 meals per day for 10 days at no extra cost to you. 20 nutritious, precooked, refrigerated meals will be delivered to your house in two installments. Meal program limited to 4 times per calendar year. Member must request meals within 7 days of discharge. **Important:** Contact Customer Service (phone numbers on back of book) to initiate meal order.	There is no coinsurance or copayment for members eligible for meal delivery.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Medical nutrition therapy This benefit is for people with conditions such as obesity, diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. 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. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. You pay 100% for weight loss treatment, including but not limited to, medications, self-help groups, exercise and weight loss programs, and dietary supplements	There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance or copayment for the MDPP benefit.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • 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	**Medicare Part B drugs may require step therapy and/or prior authorization** 20% coinsurance for Medicare Part B covered drugs	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Medicare Part B prescription drugs (continued) • 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 The following link will take you to a list of Part B Drugs that may be subject to Step Therapy **and/or Prior Authorization:** QuartzBenefits.com/MAPartBPA We also cover some vaccines under our Part B prescription drug benefit.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance or copayment for preventive obesity screening and therapy.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Opioid treatment program services 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: • 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	There is no coinsurance or copayment for Medicare-covered individual or group therapy visits	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • 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 first pint of blood that you need. • Other outpatient diagnostic tests	X-Ray: $15 copayment for Medicare Covered services Therapeutic Radiology: $60 copayment for Medicare Covered services Diagnostic Radiology: $125 copayment for Medicare Covered services Outpatient Supplies: 20% coinsurance Laboratory: $10 copayment per day for Medicare Covered services Test/Procedures: $10 copayment per day for Medicare Covered services	X-Ray: $10 copayment for Medicare Covered services Therapeutic Radiology: $60 copayment for Medicare Covered services Diagnostic Radiology: $100 copayment for Medicare Covered services Outpatient Supplies: 20% coinsurance Laboratory: $5 copayment per day for Medicare Covered services Test/Procedures: $5 copayment per day for Medicare Covered services

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. 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. **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.	$275 daily copayment on Medicare-covered outpatient hospital observation stays	There is no coinsurance or copayment for Medicare-covered outpatient hospital observation stays.

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient hospital observation (continued) 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 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.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • 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	See specific sections in the Medical Benefits Chart for copayments or coinsurance amounts that may apply.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient hospital services (continued) **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. 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 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. **Important:** Self-administered drugs in a hospital setting, such as emergency room, observation unit, surgery center, and or pain clinic are not covered under your medical benefits.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
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.	$25 copayment for each Medicare-covered individual or group therapy visit	
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). **Important:** Medicare applies an annual dollar limit on outpatient therapy series. If additional therapy is needed over Medicare coverage limitations, it must be medically necessary and prior authorized by your provider.	**You must obtain prior authorization.** $40 copayment for each Medicare-covered visit	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient substance abuse services Covered services include: Substance abuse services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$25 copayment for each Medicare-covered individual or group therapy visit	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	$200 copayment for each Medicare-covered ambulatory surgical center visit $200 copayment for each Medicare-covered outpatient surgery procedure There is no coinsurance or copayment for Medicare-covered minor surgeries. Some examples of minor surgeries are joint injections (i.e., knee, hip, elbow) or skin biopsies (i.e., removing suspicious growths or moles).	$150 copayment for each Medicare-covered ambulatory surgical center visit $150 copayment for each Medicare-covered outpatient surgery procedure There is no coinsurance or copayment for Medicare-covered minor surgeries. Some examples of minor surgeries are joint injections (i.e., knee, hip, elbow) or skin biopsies (i.e., removing suspicious growths or moles).

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (continued)	For each Medicare covered item: X-ray: $15 copayment Therapeutic Radiology: $60 copayment Diagnostic Radiology: $125 copayment Outpatient Supplies: 20% coinsurance Laboratory: $10 copayment per day Tests/Procedures: $10 copayment per day	For each Medicare covered item: X-ray: $10 copayment Therapeutic Radiology: $60 copayment Diagnostic Radiology: $100 copayment Outpatient Supplies: 20% coinsurance Laboratory: $5 copayment per day Tests/Procedures: $5 copayment per day

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Over the counter card (OTC) program Plan provides Quartz® CashCard to purchase eligible OTC wellness items in-store or online at select national retailers, such as: CVS, Walmart, Walgreens, Duane Reade, and RITE AID.* This benefit is available at the beginning of each quarter (January, April, July, October). If purchase is less than $50, or no purchase is placed, unused dollars will not carry forward to the next quarter. You will pay 100% of costs that exceed the $50 benefit per quarter. *Amounts over monthly limit do not apply toward out-of-pocket maximum	$50 per quarter for eligible OTC products at select retailers. *Amounts over the quarterly card limit do not apply toward out-of-pocket maximum	
Partial hospitalization services "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.	**You must obtain prior authorization.** $55 copayment per day for Medicare-covered partial hospitalization services Coverage does not include maintenance or activity therapy	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits		
Covered services include:		
• Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	There is no coinsurance or copayment for each primary care doctor visit for Medicare-covered benefits	There is no coinsurance or copayment for each primary care doctor visit for Medicare-covered benefits
• Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	$35 copayment for each specialist visit for Medicare-covered benefits	$25 copayment for each specialist visit for Medicare-covered benefits
• Certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare	There is no coinsurance or copayment for online medical evaluation	There is no coinsurance or copayment for online medical evaluation
• 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	See "Dental services" section in this grid.	See "Dental services" section in this grid.
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	See "Annual Wellness Visit" for more information.	See "Annual Wellness Visit" for more information.

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o 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**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) ★ Online medical evaluation and management service provided by a participating physician or other qualified health care professional. Must not have had a related evaluation and management service in the past 7 days.		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Podiatry services Covered services include: • 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	$35 copayment for each Medicare-covered visit, limit 6 visits per year $35 copayment for each routine foot care visit, limit 6 visits per year	$25 copayment for each Medicare-covered visit, limit 6 visits per year $25 copayment for each routine foot care visit, limit 6 visits per year
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance or copayment for an annual PSA test.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	**You must obtain prior authorization for purchases or repairs and rentals.** 20% coinsurance for Medicare-covered items	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and or an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. ★ **No limit** to the number of pulmonary rehabilitation visits allowed based on medical necessity.	$20 copayment for each covered pulmonary therapy visit	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Quartz® CashCard Program Use your pre-funded Quartz® CashCard towards each of the supplemental benefits below: • Fitness memberships- swipe your card at any licensed fitness facility that provides membership programs. • Over-the-counter items- purchase eligible OTC wellness items in-store or online at select national retailers, such as: CVS, Walmart, Walgreens, Duane Reade, and RITE AID.	Quartz® CashCard funds the Fitness benefit at $25 a month and the Over-the-Counter Program at $50 a quarter	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance or copayment for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance or copayment for the Medicare covered counseling and shared decision making visit or for the LDCT.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance or copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies	There is no coinsurance or copayment for Medicare-covered kidney disease education services 20% coinsurance for Medicare-covered renal dialysis 20% coinsurance for Medicare-covered services	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Services to treat kidney disease (continued) • 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) **Certain drugs for dialysis are covered under your** Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Coverage is limited to 100 days each benefit period (combined limit for skilled nursing facility and swing bed) based on medical necessity and skilled nursing needs. ★ No prior hospital stay is required. Covered services include but are not limited to: • 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 with the first pint of blood that you need.	**You must obtain prior authorization** Days 1-20: $0 copayment per day Days 21-100: $160 copayment per day	**You must obtain prior authorization** Days 1-20: $0 copayment per day Days 21-100: $150 copayment per day

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Skilled nursing facility (SNF) care (continued) • 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 Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital		

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: 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. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: 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.	There is no coinsurance or copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
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: • 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 ★ No limit to the number of SET PAD visits allowed based on medical necessity.	$20 copayment for each covered supervised exercise therapy visit	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Swing Bed Coverage is limited to 100 days each benefit period (combined limit for skilled nursing facility and swing bed) based on medical necessity and skilled nursing needs. ★ No prior hospital stay is required. Facility charges and costs associated with an approved swing bed stay when meeting the following criteria: • Your physician must certify your stay as medically necessary and daily skilled needs are identified. • You must be confined and received treatment for which you are hospitalized. • Intensity and frequency of services requires 24-hour nursing intervention. • Frequent or daily physician monitoring is needed. • Services will not exceed seven (7) days and usage will apply to the 100-day benefit period limit (skilled nursing facility and swing bed).	**You must obtain prior authorization** Days 1-20: $0 copayment per day Days 21-100: $160 copayment per day	**You must obtain prior authorization** Days 1-20: $0 copayment per day Days 21-100: $150 copayment per day

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. ★ Urgently needed medical care is covered world-wide.	$40 copayment for Medicare-covered urgently needed care visits	$30 copayment for Medicare-covered urgently needed care visits

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Virtual visits Virtual visits are an episode of physician-patient interactive health care via telephone or other telecommunication devices that do not involve the patient and provider being in the same room at the same time. Virtual Visits make use of video conferencing technology where the provider and patient can see each other over their own respective device screens. Virtual Visits are meant for conditions similar to what a beneficiary would utilize urgent care for, such as (but not limited to) • Allergies • Cough • Fever • Cold/Flu symptoms • Runny nose/Sinus congestion • Sore throat **Important:** Must use health system sponsored application	There is no coinsurance or copayment for virtual visits.	

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Vision care Covered services include: • 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.)	No coinsurance or copayment for the first routine eye exam each calendar year $35 copayment for each additional eye exam No coinsurance or copayment for refraction up to one service every calendar year. All subsequent refractions are not-covered. Any amount over the Medicare-covered amount for frames and lenses following cataract operation	No coinsurance or copayment for the first routine eye exam each calendar year $25 copayment for each additional eye exam No coinsurance or copayment for refraction up to one service every calendar year. All subsequent refractions are not-covered. Any amount over the Medicare-covered amount for frames and lenses following cataract operation

Services that are covered for you	UW Health IL Quartz Medicare Advantage **Value** **What you must pay** when you get these services	UW Health IL Quartz Medicare Advantage **Elite** **What you must pay** when you get these services
Vision care (continued) ★ **Routine eye exam and eye refraction** The first routine eye exam each calendar year is covered at 100%. Additional eye exams within the year are subject to copayment ★ Limit for routine eyewear every year (for contacts, frames, eyeglass lenses, and eyewear upgrade at participating network providers)* **Important:** Amounts over annual limit for routine eyewear do not apply toward out-of-pocket maximum	$100 limit for routine eyewear every year (for contacts, frames, eyeglass lenses, and eyewear upgrade at participating network providers)	$100 limit for routine eyewear every year (for contacts, frames, eyeglass lenses, and eyewear upgrade at participating network providers)

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

Section 2.2 Extra "optional supplemental" benefits you can buy

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

The Quartz Medicare Advantage Optional Dental Rider is an optional supplemental benefit package. This dental coverage is not covered by Original Medicare and not included in your benefit package as a plan member. If you want this optional supplemental benefit, you must sign up for it, and pay an additional monthly premium of $48.10. This supplemental benefit is administered by Delta Dental and available to members who have enrolled in Quartz Medicare Advantage HMO plans.

How Does the Quartz Medicare Advantage Optional Dental Rider Work?

Enrollment in the Optional Dental Rider adds the additional $1000 in dental coverage on top of your embedded dental benefits as an enrolled Quartz Medicare Advantage member, see your Dental Service plan limits in Chapter 4 Section 2.1. Services include preventive and comprehensive benefit coverage, see section below around limitations and exclusions. To utilize the Quartz Medicare Advantage Optional Dental Rider you will continue to use the Delta Dental ID card issued to you.

In this plan, you may receive your care from either an in-network or out-of-network dentist. If you use an out-of-network dentist, you will incur a share of the cost. Services can be provided by any dentist and will be processed based on Delta Dental's Fee Schedule. If you receive services from a dentist that does NOT participate in the Delta Dental Medicare Advantage Network, you will be responsible for the difference between Delta Dental's payment and the amount charged by the non-participating dentist. To avoid experiencing out of pocket charges, you may choose to instead use a Delta Dental Medicare Advantage Network dentist. You may call the Delta Dental Customer Service number on the back of your Delta Dental ID card for Fee Schedule amounts and to find Delta Dental's Medicare Advantage Network participating dentists.

Optional Supplemental Benefit: **Quartz Medicare Advantage Optional Dental Rider**	**What you must pay** When you get these services
The Quartz Medicare Advantage Optional Dental Rider is an optional supplemental benefit that you must sign up for and pay an additional premium. With this benefit, you get preventive and comprehensive dental services.	You pay an additional monthly premium amount of $48.10
Plan covers the following services: Oral Exams, Prophylaxis (Cleaning), Fluoride Treatment, Dental X-Rays, Non-routine Services, Diagnostic Services, Restorative Services, Endodontics, Periodontics, Extractions, Prosthodontics, and Other Oral/Maxillofacial Surgery	There is no coinsurance or copayment for optional dental services You pay amounts over the Delta Dental Fee Schedule
The plan pays up to Calendar Year Maximum of $1,000. All covered services are subject to the Calendar Year Maximum and the Delta Dental Fee Schedule. Services received from a dentist in an emergency situation are subject to plan rules and cost sharing.	Amounts over the Fee Schedule do not apply to plan maximum out-of-pocket

How to Enroll in the Quartz Medicare Advantage Optional Dental Rider

The Quartz Medicare Advantage Optional Dental Rider is not part of your Medicare Advantage plan. You must purchase this rider separately and pay an additional monthly amount. Your dental premium must be paid the same way you pay your medical premium. Please refer to Chapter 1, Section 4.2 of this Evidence of Coverage (*There are several ways you can pay your plan premium*) for more information about your payment options. To enroll you will need to meet the criteria and timelines specified below:

Enrollment Timelines:

- At the time of initial enrollment in a Quartz Medicare Advantage HMO plan (for newly eligible beneficiaries)
- Within the first month of your initial enrollment in Quartz Medicare Advantage (coverage will be effective the first of the following month)
- During the Annual Enrollment Period (October 15 – December 7 of each year) for a start date of January 1 of the following year
- From January 1 – January 31 for an effective date of February 1
- At the time of enrollment in a Quartz Medicare Advantage HMO plan during a Special Election Period (SEP)

If you did not sign up at the time of your initial enrollment you will need to complete a Plan Benefit Selection Form and return by the applicable timeline specified above. To receive the Optional Supplemental Dental Rider form you must contact Customer Service at (800) 394-5566; TTY/TDD 711, (800) 877-8973.

How to Disenroll from the Quartz Medicare Advantage Optional Dental Rider

You may voluntarily disenroll from the Quartz Medicare Advantage Optional Dental Rider at any time throughout the year as long as you provide advance notice in proper documentation. You can email, mail or fax either option noted below:

Disenrollment documentation options:

- Complete the Quartz disenrollment form available on QuartzBenefits.com/MedicareAdvantage website, -OR-
- Provide a signed letter requesting disenrollment. Your letter must clearly state that you wish to disenroll from Quartz Medicare Advantage Optional Dental Rider and include your printed name and Quartz Medicare Advantage member ID number.

Completed forms must be sent to the Quartz Enrollment Department. Your disenrollment will be effective on the first day of the month following receipt of your form. **Disenrolling from the Quartz Medicare Advantage Optional Dental Rider does not impact your enrollment in your Quartz Medicare Advantage HMO plan.**

Send completed forms to:

Quartz Medicare Advantage
Attention: *Enrollment*
840 Carolina Street
Sauk City, Wisconsin 53583
Fax Number: (608) 881-8396
Email address: QuartzBenefits.com/MedicareAdvantage

Contact Customer Service if you need more information on how to disenroll using these options.

If you disenroll from the Quartz Medicare Advantage Optional Dental Rider, you cannot re-enroll in the Quartz Medicare Advantage Optional Dental Rider until the next Optional Supplemental Benefits election period. The Optional Supplemental Benefits election periods are shown earlier in this section under "How to Enroll in the Quartz Medicare Advantage Optional Dental Rider."

If you disenroll from the Quartz Medicare Advantage HMO plan, you will automatically be disenrolled from the Quartz Medicare Advantage Optional Dental Rider. No additional premium will be collected once you are disenrolled from the Optional Supplemental Benefit. If you paid for additional months, you will receive a refund.

If you fail to pay the monthly premium for the Quartz Medicare Advantage Optional Dental Rider but you do pay enough to meet your monthly premium for your Quartz Medicare Advantage HMO plan, you will lose the optional supplemental benefits included in the Quartz Medicare Advantage Optional Dental Rider, but will remain enrolled in your Quartz Medicare Advantage HMO plan. You will be notified in writing if the Quartz Medicare Advantage Optional Dental Rider is removed from your Quartz Medicare Advantage HMO coverage. Your premium for the Quartz Medicare Advantage Optional Dental Rider is due on the 1st of each month. This is the same date your premium for your Quartz Medicare Advantage HMO coverage (if applicable) and/or Part D Late Enrollment Penalty is due. All premium payments apply first to your medical coverage, and the remainder will apply to your Quartz Medicare Advantage Optional Dental Rider.

If you fail to pay your full Quartz Medicare Advantage HMO plan premium, you may be at risk for disenrollment. Please see Section 5.1 in Chapter 8 of this Evidence of Coverage for additional information regarding failure to pay plan premiums. If you are disenrolled from the Quartz Medicare Advantage Optional Dental Rider, you cannot re-enroll in the Quartz Medicare Advantage Optional Dental Rider until the next Annual Enrollment Period (AEP) or if you qualify for a Special Election Period (SEP), and you will be responsible to pay any outstanding balance.

Pre-treatment Estimates
For details around pre-treatment estimates reference the Delta Dental Certificate of Coverage available on the QuartzBenefits.com/MedicareAdvantage website.

Limitations and Exclusions:

- Payment is subject to the plan benefits (e.g. Calendar Year Maximum), limitations and exclusions at the time the claim is submitted.
- If a method of treatment is more costly than is customarily provided, benefits will be paid on the least costly method of treatment, and you will be responsible for the remaining balance.
- Coverage is limited to those services listed in the Quartz Medicare Advantage Optional Dental Rider Benefit Chart. If a service is not listed, it is not covered.
- Per the Delta Dental Certificate of Coverage, Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits or Coverage Code List. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance of some other arrangement for which you are eligible):
    - Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
    - Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
    - Services started or appliances started before a person became eligible under This Plan.
    - Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.

- General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
- Charges for hospitalization, laboratory tests, and histopathological examinations.
- Charges for failure to keep a scheduled visit with the Dentist.
- Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
- Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
- Services or supplies, as determined by Delta Dental, which are specialized techniques.
- Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
- Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received due to an act of war, declared or undeclared.
- Services or supplies covered under a hospital, surgical/medical (including Medicare Advantage), or prescription drug program.
- Services or supplies that are not within the categories of Benefit selected by your Medicare Advantage Organization and that are not covered under the terms of this Certificate.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Interim caries arresting medicament.
- Preventive contract programs (including oral hygiene instruction, caries, susceptibility tests dietary contract, tobacco counseling, home care medicaments, etc.
- Sealants.
- Space maintainers.
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic applicants or space maintainers.
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
- Veneers.
- Prefabricated crowns used as final restorations on permanent teeth.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.
- Implant/abutment supported interim fixed denture for edentulous arch.
- Soft occlusal guard appliances.
  Paste-type root canal fillings on permanent teeth.
- Replacement, repair, relines or adjustments of occlusal guards.
- Chemical curettage.

- Services associated with overdentures.
- Metal bases on removable prostheses.
- The replacement of teeth beyond the normal complement of teeth.
- Personalization or characterization of any service or appliance.
- Temporary crowns used for temporization during crown or bridge fabrication.
- Posterior bridges in conjunction with partial dentures in the same arch.
- Precision attachments and stress breakers.
- Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
- Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
- Appliances, restorations, or services for the diagnosis or treatment of
- disturbances of the temporomandibular joint (TMJ).
- Orthodontic Services.
- Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
- Myofunctional therapy.
- Mounted case analyses.
- Any and all taxes applicable to the services.
- Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

The Quartz Medicare Advantage Optional Dental Rider is administered by Delta Dental of Wisconsin, LLC.

**These services are covered by your medical benefit when deemed medically necessary.*

Section 2.3 Getting care using our plan's optional visitor/traveler benefit

Quartz Medicare Advantage provides a visitor/travel benefit to members who are temporarily traveling outside of the plan's service area. Under this visitor/travel benefit you may receive all plan covered services under this Evidence of Coverage at in-network cost-sharing. This benefit gives members 3 months of visitor/travel benefits up to 2 times per calendar year. Activation is required to utilize benefit.

It is important whenever you receive medical care or non-routine services from out-of-state providers while using your visitor/traveler benefit that you confirm they accept Medicare assignment, and agree to bill us for the services.

When using your travel benefit and in need of dental services, you will need to contact Delta Dental before seeking care. Contact Delta Dental at (866) 548-0292.

Requirements:

- You **must** notify us in advance of the start date for each occurrence when you will be traveling outside of our service area and you want to activate the visitor/traveler benefit. Please call the Customer Service number in Chapter 2 of this booklet.
- No benefits are available under visitor/traveler if this coverage is not in effect on the date of service.
- If your visit/travel meets the criteria for this benefit, you will be approved for 3 months of continuous travel.
- If you will be out of the service area longer than 3 months and want to extend your visitor/travel benefit, you must call Customer Service and can extend up to 3 more months, **for a total of up to 6 months.**
- Under no circumstances is this visitor/traveler benefit available for greater than a total of 6 months during a calendar year.
- Coverage is available when you are visiting/traveling in the United States **outside of:**
  - Iowa, Illinois, Wisconsin, and Minnesota

You are covered for Urgent and Emergency services anywhere in the United States. Cost-sharing is the same for in-network and out-of-network Urgent and Emergency services.

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. If a service is "excluded," it means that this plan doesn't cover the service.

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		✓ Covered for chronic low back pain
Ambulance – response but not transport		✓ Limitations and coverage guidelines established by Original Medicare
Any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license.	✓	
Biofeedback, including psychiatric therapy with biofeedback, except when it is considered medically necessary and covered under Original Medicare.	✓	
Chelation therapy	✓	
Clinical trials are subject to all terms, conditions, restrictions, exclusions, and other coverage under our Plan.		✓ See Chapter 3 Section 5 for coverage of Medicare-approved clinical trials.
Colorectal cancer screening – CT colonography	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Contraceptive management, including all services, items, supplies or drugs. Examples: Implantable contraceptive device and delivery system, cervical cap, condom, diaphragm, foam, gel, hormone patch, IUD, pills, spermicide, vaginal ring, elective sterilization procedures.	✓	
Cosmetic surgery or procedures		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Drugs (pill form and those used for self-injection) that meet the definition of a Part D drug; this includes drugs that may be provided or administered by staff, or self-administered in a hospital outpatient setting such as emergency room, observation unit, and surgery center or pain clinic if not required for the medical condition being treated. Please refer to Chapter 5 to determine your coverage in these situations.		✓ Limitations and coverage guidelines established by Original Medicare
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance).		✓ Covered when medically necessary
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Immunizations when covered under Part D following Original Medicare guidelines	✓ Zostavax, Shingrix	✓ Tetanus-Diphtheria-Pertussis vaccines (when received for injury)
Naturopath services (uses natural or alternative treatments).	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Outpatient prescription drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.	✓	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private duty nurse	✓	
Private room in a hospital.		✓ Covered only when medically necessary.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids. Radial keratotomy, LASIK surgery, vision therapy, other low vision aids, eyeglasses or contact lenses, intraocular lenses for vision correction (astigmatism or presbyopia).	✓ Repairs to eyewear	✓ See Vision care, in the Medical Benefits Chart in Section 2, above, for supplemental benefit information.
Replacement drugs due to being lost, stolen, damaged or destroyed.		✓
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care	✓ Chiropractic services for preventative/maintenance	✓ Manual manipulation of the spine to correct a subluxation, Lab and x-ray, and examinations.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care • The cutting or removal of corns and calluses. • The trimming, cutting, clipping, or debriding of nails. Other hygienic and preventative maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other services performed in the absence of localized illness, injury, or symptoms involving the foot.		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes). See Podiatry services, in the Medical Benefits Chart in Section 2, above, for supplemental benefit information.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine or elective services, when provided by an out of network provider without prior approval by a Quartz Medicare Advantage Medical Director. Example: Lab work or medical care that is foreseen and not considered urgently needed services or a medical emergency.	✓	
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.	✓	
Services provided under another plan for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. Examples include coverage by Workers' Compensation, medical payment coverage under no-fault or underinsured automobile insurance, or coverage required under similar legislation. If coverage under this legislation is optional for you because you could have elected it, or could have had it elected for you, benefits will not be paid for any injury or sickness that would have been covered under the other plan had it been elected.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Supportive devices for the feet (put by foot stuff?) Supportive devices for the feet (such as custom molded orthotics and removable foot inserts.)		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity		✓ Limitations and coverage guidelines established by Original Medicare
Telemedicine or online services that are not included in the CMS covered Telehealth benefit.		✓
Third-party examinations and related services performed or requested for: licensing, insurance, sports physicals, or examinations ordered by a court are excluded unless otherwise stated as a Covered Service. Coverage will be provided if the third-party physical exam is substituted for a covered wellness exam if performed by a Plan Provider. Example: Screening for TB performed and/or requested by primary care provider (PCP)		✓ Coverage will be provided if the third-party physical exam is substituted for a covered wellness exam if performed by a Plan Provider.
Transportation which is routine or non-emergent by other transport providers or services. Examples: Taxi, bus or van	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Weight loss treatment, including but not limited to medications, self-help groups, exercise and weight loss programs and dietary supplements.	✓	
Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.	✓	

*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.

*Immediate family is defined as spouse, mother, father, grandparents, children, grandchildren, brothers, sisters, mother-in-law, father-in-law, brothers-in-law, sisters-in-law, daughters-in-law, and sons-in-law. Adopted and step relationships are also included in immediate family.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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 ask us to pay our share of the cost of your covered services 139

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment 139

SECTION 2 How to ask us to pay you back or to pay a bill you have received 140

Section 2.1 How and where to send us your request for payment 140

SECTION 3 We will consider your request for payment and say yes or no 141

Section 3.1 We check to see whether we should cover the service and how much we owe 141

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..... 142

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

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

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

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

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

   You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the Quartz Medicare Advantage Member Claim Form, bill, along with documentation of any payments you have made.
   - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us the Quartz Medicare Advantage Member Claim Form, this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

   - You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance

billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the Quartz Medicare Advantage Member Claim form, bill, along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit the Quartz Medicare Advantage Member Claim Form, bill, and documentation of any payments for us to handle the reimbursement.

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

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

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

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

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

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

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

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

Quartz Medicare Advantage
Attention: *Claims Dept.*
840 Carolina Street
Sauk City, Wisconsin 53583

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, *Where to send a request asking us to pay for our share of the cost for medical care you have received*.

For timely processing, we encourage members to submit bills or receipts to our plan within 12 months of the date you received the service, item, or drug.

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

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

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

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

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

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan 145

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.) 145

Section 1.2 We must ensure that you get timely access to your covered services 145

Section 1.3 We must protect the privacy of your personal health information 146

Section 1.4 We must give you information about the plan, its network of providers, and your covered services 147

Section 1.5 We must support your right to make decisions about your care 148

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made 150

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected? 150

Section 1.8 How to get more information about your rights 151

SECTION 2 You have some responsibilities as a member of the plan 151

Section 2.1 What are your responsibilities? 151

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

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

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and 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 Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Kristie Meier, Compliance Officer at (800) 362-3310. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service (phone numbers are printed on the back cover of this booklet) for additional information.

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

As a member of UW Health IL Quartz Medicare Advantage, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at QuartzBenefits.com/MedicareAdvantage.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about

how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

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

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

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

We follow state and federal requirements in regard to Advance Directives, and have a responsibility to you to ensure that your wishes are followed by:

- Ensuring your provider has documented your advance directive in a prominent part of your current medical records, whether or not your advance directive has been executed;
- Applying no conscientious objections to any services;

- Educating our staff about our policy, procedure and responsibilities for advance directives; and
- Providing community education regarding advance directives.

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

Method	Illinois Department of Public Health – Contact Information
CALL	(217) 782-4977
WRITE	Illinois Department of Public Health 525-535 West Jefferson Street Springfield, Illinois 62761

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

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

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

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

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

Is it about something else?

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "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 users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

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

  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) *OR* coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
  - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).

  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

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 157
Section 1.1 What to do if you have a problem or concern 157
Section 1.2 What about the legal terms? 157

SECTION 2 You can get help from government organizations that are not connected with us 158
Section 2.1 Where to get more information and personalized assistance 158

SECTION 3 To deal with your problem, which process should you use? 158
Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? 158

COVERAGE DECISIONS AND APPEALS 159

SECTION 4 A guide to the basics of coverage decisions and appeals 159
Section 4.1 Asking for coverage decisions and making appeals: the big picture 159
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal 160
Section 4.3 Which section of this chapter gives the details for your situation? 161

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal 162
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 162
Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want) 163
Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan) 167
Section 5.4 Step-by-step: How a Level 2 Appeal is done 170
Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care? 172

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon 173
Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights 173

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date ... 175
Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date ... 178
Section 6.4 What if you miss the deadline for making your Level 1 Appeal? ... 179

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon ... 182
Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services ... 182
Section 7.2 We will tell you in advance when your coverage will be ending ... 182
Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time ... 183
Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time ... 185
Section 7.5 What if you miss the deadline for making your Level 1 Appeal? ... 186

SECTION 8 Taking your appeal to Level 3 and beyond ... 189
Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests ... 189

MAKING COMPLAINTS ... 191

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns ... 191
Section 9.1 What kinds of problems are handled by the complaint process? ... 191
Section 9.2 The formal name for “making a complaint” is “filing a grievance” ... 193
Section 9.3 Step-by-step: Making a complaint ... 193
Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization ... 194
Section 9.5 You can also tell Medicare about your complaint ... 195

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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 is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

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

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).

- You **can get free help** from your SHIP (see Section 2 of this chapter).
- **Your doctor can make a request for you.** 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. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (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 www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at QuartzBenefits.com/Medicare Advantage.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

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

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information

from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

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

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

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

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

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

   NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.

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

Which of these situations are you in?

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

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

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

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

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

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

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request **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,** for a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

- **A fast coverage decision means we will answer within 72 hours 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,** for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. 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" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**

- You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours.**
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

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

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

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

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

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at QuartzBenefits.com/MedicareAdvantage.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, 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 for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal. We do not charge a fee.
    - If you wish, you and your doctor may give us additional information to support your appeal.

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

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- 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."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

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

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.** If we decide to take extra days to make the decision, 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 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. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. 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 to gather 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 decide to take extra days to make the decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days 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 answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- 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**. We do not charge you a fee.
- 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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if 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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
  - However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

The Independent Review Organization will tell you 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 or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **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 under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

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

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

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

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

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

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

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

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

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

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

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or

nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24

hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

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.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)

  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, 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.

Ask for a "fast review":

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

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

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

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge.**" You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you 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 second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. 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. 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 by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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?

You can appeal to us instead

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

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

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

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

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

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

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

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

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

- In this situation, we will use the "fast" deadlines rather than the "standard" deadlines for giving you the answer to this review.

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

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

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

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

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

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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

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

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

The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

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

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

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

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

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

Section 7.1 *This section is about three services **only**:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

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

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

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

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

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.

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

Legal Terms
In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)
The written notice is called the "**Notice of Medicare Non-Coverage."**

2. You will be asked to sign the written notice to show that you received it.

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

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

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

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

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

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

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care

received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

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

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage.**"

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

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

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

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

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by 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 reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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 in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline

for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

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

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

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

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

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

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

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

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

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

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

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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

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

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

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

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

necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

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

  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the 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. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The 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** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - 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 might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

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

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. If you have questions or require language assistance, please call Customer Service at (800) 394-5566. For people who are deaf, hard of hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Interpreter services are provided free of charge to you. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m.
- **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.
  - **Procedures for Filing a Standard Complaint (Grievance)**
    You have the right to file a grievance verbally or in writing up to 60 days after the event. You may call Customer Service at the numbers listed above or on the back cover of this booklet to file a verbal grievance, or send a written grievance to:

    For Medical Complaints Mail to:
    Quartz Medicare Advantage
    Attention: Appeals Specialists
    840 Carolina Street
    Sauk City, Wisconsin 53583

    We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your grievance. Your grievance will be reviewed and investigated by the appropriate decision making level within our plan.

- **Procedures for Filing a "Fast" or Expedited Complaint (Grievance)**
  In certain cases, you have the right to ask for a "fast" grievance, meaning we will answer your grievance within 24 hours. Only those grievances which involve the following criteria will be considered for an expedited review:

  - Our refusal to grant a request for an expedited coverage determination or redetermination; or when we extend the time frame to make an expedited coverage determination or redetermination.

  A "fast" or expedited grievance can be submitted verbally or in writing using the same information for a standard grievance which is listed above. The request should include any relevant information to support the request. Your complaint will be reviewed and investigated by the appropriate decision making level within our plan.

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

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

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered 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 we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

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

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about UW Health IL Quartz Medicare Advantage 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.

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

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction 198
Section 1.1 This chapter focuses on ending your membership in our plan 198

SECTION 2 When can you end your membership in our plan? 198
Section 2.1 You can end your membership during the Annual Enrollment Period 198
Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period 199
Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period 199
Section 2.4 Where can you get more information about when you can end your membership? 200

SECTION 3 How do you end your membership in our plan? 200
Section 3.1 Usually, you end your membership by enrolling in another plan 200

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan 201
Section 4.1 Until your membership ends, you are still a member of our plan 201

SECTION 5 UW Health IL Quartz Medicare Advantage must end your membership in the plan in certain situations 202
Section 5.1 When must we end your membership in the plan? 202
Section 5.2 We cannot ask you to leave our plan for any reason related to your health 203
Section 5.3 You have the right to make a complaint if we end your membership in our plan 203

SECTION 1 Introduction

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

Ending your membership in UW Health IL Quartz Medicare Advantage may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

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

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

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

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

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

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

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - 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).

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

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

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2022*** handbook.
  - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare

prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

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

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from UW Health IL Quartz Medicare Advantage when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from UW Health IL Quartz Medicare Advantage when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from UW Health IL Quartz Medicare Advantage when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave UW Health IL Quartz Medicare Advantage, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for

information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

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

SECTION 5 UW Health IL Quartz Medicare Advantage must end your membership in the plan in certain situations

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

UW Health IL Quartz Medicare Advantage 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 move out of our service area.
- If you are away from our service area for more than twelve months.
    - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
    - Go to Chapter 4, Section 2.3 for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for *two calendar months*.
    - We must notify you in writing that you have *two calendar months* to pay the plan premium before we end your membership.

Where can you get more information?

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

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

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

UW Health IL Quartz Medicare Advantage is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

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

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

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law 206

SECTION 2 Notice about non-discrimination 206

SECTION 3 Notice about Medicare Secondary Payer subrogation rights 206

SECTION 4 Notice of coordination of benefits 206

SECTION 5 Notice of subrogation and third-party recovery 208

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

If you want more information or have concerns about discrimination or unfair treatment, 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.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, UW Health IL Quartz Medicare Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice of coordination of benefits

You are required to tell our Plan if you have additional health insurance and to let us know whenever there are any changes in your additional insurance coverage. Contact Customer

Service to let us know the type of additional insurance you might have. The types of additional insurance you might have include the following:

- Coverage that you have from an employer's group health insurance for *employees* or *retirees*, either through yourself or your spouse. Generally, if you are age 65 or older and covered by a group health plan because of your current employment or the current employment of a spouse of any age, our Plan is the secondary payer if the employer has 20 or more employees. This means that the group plan pays first on your hospital and medical bills. The insurance company that pays its share of your bills *first* is called the "primary payer." Then the other company or companies that are involved – called the "secondary payers" – each pay their share of what is left of your bills.

If the group health plan didn't pay your entire bill, the doctor or other provider should send the bill to our Plan for secondary payment. Our Plan will review what your group health plan paid for covered health care services, and pay any additional approved amounts with the exception of copayments or coinsurance amounts you are responsible for under our Plan. You will have to pay the cost of services that our Plan or the group health plan does not cover.

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, Workers' Compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this Evidence of Coverage for services rendered in connection with your job-related illness or injury. If benefits are paid by the plan and you receive Workers' Compensation for the same incident, the plan is entitled to full recovery for the benefits it has paid.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay," no-fault, automobile, accident, or liability coverage are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury. Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment. If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. This Plan will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier. If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the Subrogation and third-party recovery section for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second on eligible services depend on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "Medicare and Other Health Benefits: Your Guide to WHO PAYS FIRST." It is CMS Pub. No. 02179. Other details are explained in the Medicare Secondary Payer rules, which are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 9 of this Evidence of Coverage.

SECTION 5 Notice of subrogation and third-party recovery

Subrogation

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity, or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness, or condition. We are entitled to exercise the same rights of subrogation and recovery that are accorded to the Medicare Program under the Medicare Secondary Payer rules.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive, including but not limited to the following:

1. Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third-party entity;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or

4. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation or restitution, for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our representatives and to take any actions or steps necessary to secure our lien, including but not limited to:

1. Responding to requests for information about any accidents or injuries;
2. Responding to our requests for information and providing any relevant information that we have requested; and
3. Participating in all phases of any legal action we commence in order to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. If you fail to comply with the requirements set for above, it shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

Reimbursement

The Plan shall have the right to receive payment of those expenses that we paid that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under our plan. When the claim is settled or any amount is paid to the covered person, his or her legal representative or guardian, or estate, the person receiving such funds must immediately pay to us any amounts you recover by judgment, settlement, award, recovery, or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in our plan.

Antisubrogation rules do not apply

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine. We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness, or condition.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

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

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of UW Health IL Quartz Medicare Advantage, 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. Chapter 2 explains how to contact CMS.

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

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

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

Copayment (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, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

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

Covered Services – The general term we use 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 is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

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

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

Health Maintenance Organization – There are different types of Medicare Advantage Plans. This is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Our organization contracts with the Federal Government. A health maintenance organization (HMO) is a type of managed care organization that provides a form of health care coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract.

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

Home Health Care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

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

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a

team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not a cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY/TDD users should call 1-877-486-2048).

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. For example, 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 – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and 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. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Necessary – medical treatment, services or supplies that are required to identify or treat a sickness or injury and which, as determined by us, are:

1. Consistent with the symptoms, diagnosis or treatment of your medical condition;
2. Appropriate with regard to standards of good medical practice;
3. Not primarily for your convenience or your immediate family, or that of your physician or another provider;
4. The most appropriate and cost-effective level of medical service or supplies that can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided as an outpatient;
5. Of proven value or usefulness; and
6. Compliant with your provider's treatment plan.

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

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

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

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, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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

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

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

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

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

Observation Level of Care - are those services furnished by a hospital on its premises, including the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible (inpatient) admission to the hospital or release to home or another care setting. Hospital outpatient observation services are covered as noted in the Outpatient Hospital Services section in Chapter 4.

Online Visit (for example, E-Visits) - A communication between a patient and their provider through an online patient portal.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

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

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

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

Part C – see "Medicare Advantage (MA) Plan."

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

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval before you receive services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are only covered if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary. Your plan will not review a prior authorization after you receive medical services or certain drugs.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Referral – The form prepared in writing by a participating provider for you in order for you to receive coverage for medical treatment, services, or supplies from a non-participating provider. Medical care, treatment, services or supplies that are received through a referral are subject to the exclusions and limitations of this *Evidence of Coverage*. Referrals must be submitted and approved in writing by our Medical Director for a covered expense before any recommended treatment, services or supplies are obtained.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF/Swing Bed) Care – A level of care in a SNF/Swing Bed ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

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

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

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

Telehealth Visit- A visit with a provider that uses telecommunication systems between a provider and a patient.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Veterans Affairs - Services provided to veterans in Veterans Affairs (VA) facilities.

Virtual Visit- A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images summitted by an established patient.

Workers' Compensation Act - Any sickness or injury eligible for or covered by any federal, state or local government Worker's Compensation Act or Occupational Disease Law or other legislation of similar purposes.

NOTICE OF NONDISCRIMINATION

Quartz Medicare Advantage (HMO) is the marketing name operating under the entities of Quartz Health Plan Corporation and Quartz Health Plan MN Corporation. These companies are separate legal entities. In this notice, "we" refers to these companies. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

- We provide 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)
- We provide free language services to people whose primary language is not English, such as –
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at **(800) 362-3310**.

If you believe that we have 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 –

Kristie Meier, Compliance Officer; 840 Carolina Street, Sauk City, WI 53583
Phone: (800) 362-3310; TTY: 711 or toll free (800) 877-8973; Fax: (608) 644-3500
Email: AppealsSpecialists@QuartzBenefits.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kristie Meier, Compliance Officer, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **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
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

Quartz

Multi-Language Insert

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-394-5566 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-394-5566 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-394-5566（TTY：711）。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-394-5566 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة من أجلك، يُرجى الاتصال على الرقم 1-800-394-5566 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-394-5566 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-394-5566 (711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-394-5566 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-394-5566 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-394-5566 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-394-5566 (ATS : 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-394-5566 (መስማት ለተሳናቸው: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-394-5566 (TTY: 711) पर कॉल करें।

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-394-5566 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-394-5566 (TTY: 711).

UW Health IL Quartz Medicare Advantage Customer Service

Method	Customer Service – Contact Information
CALL	(800) 394-5566 Calls to this number are free. A Customer Service representative is available to assist you Monday through Friday from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, we are also available to assist you on Saturdays and Sundays from 8:00 a.m. to 8:00 p.m. If you are calling outside of our normal office hours, you can leave a confidential voicemail message and your call will be returned on the next business day. If you would like an appointment with a member of our Customer Service team, we are available upon request. For more information on scheduling, please call (800) 394-5566. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	For people who are deaf, hard or hearing or speech impaired please call TTY/TDD 711, (800) 877-8973. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. You may also call through a video relay service company of your choice. Calls to this number are free.
FAX	(608) 643-2564, Attention: Customer Service
WRITE	Quartz Medicare Advantage Attention: Customer Service 840 Carolina Street, Sauk City, Wisconsin 53583 Email: CustomerService@QuartzBenefits.com Secure Member Portal: QuartzMyChart.com
WEBSITE	QuartzBenefits.com/MedicareAdvantage

State Health Insurance Assistance Programs (SHIP)

State Health Insurance Assistance Programs (SHIP) are state programs that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Senior Health Insurance Program (Illinois SHIP) – Contact Information
CALL	(800) 252-8966
TTY	(888) 206-1327
WRITE	Illinois Department on Aging One Natural Resources Way, #100 Springfield, Illinois 62702-1271
WEBSITE	www.illinois.gov/aging/ship

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