

2026 Evidence of Coverage
Aspirus Health Plan Elite (PPO)

Notice of Nondiscrimination

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

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715.631.7411 (voice)** or toll free at **1.855.931.4850 (voice)**, **715.631.7413 (TTY)**, or **1.855.931.4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address

Attn: Appeals and Grievances
Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715.631.7439

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

U.S. Department of Health and Human Services 200
Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)

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

Notice of Availability

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

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تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضاً المساعدات والخدمات المساعدة الإضافية لتوفير المعلومات بتنسيق يسهل الوصول إليها مجاناً. يمكنك الاتصال على الرقم 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ស្តីមជ្ជាបជាជំណើង៖ ប្រសិទបើម្នាកិយាយភាសាទីផ្សេងៗ ដែល
សេវាគារជំនួយភាសាតកិត្តិកដែលមានច្បាស់បានផ្តល់ជំនួយស្រាប់ម្នាក់ ជំនួយ
ទិន្នន័យសម្រាប់ដែលមានច្បាស់បានផ្តល់ជំនួយភាសាទីផ្សេងៗ ដែលមានច្បាស់បានផ្តល់ជំនួយ
ខ្លួន 715.631.7411/1.855.931.4850
(TTY: 715.631.7413/1.855.931.4852) ។

請注意：如果您講粵語，可得免費語言協助服務。還可免費提供適當的輔助工具和服務，能以無障礙格式提供資訊。請致電 715.631.7411/1.855.931.4850 (聽障專線：715.631.7413/1.855.931.4852)。

请注意：如果您说普通话，我们可为您免费提供语言协助服务。此外，我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852)。

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS : 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) an.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नन: शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी नन: शुल्क उपलब्ध हैं। 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852) पर कॉल करें।

TSWM SEEB: Yog tias koj hais tau lus Hmoob, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj siv. Kuj tseem muaj cov kev pab txhawb ntxiv thiab cov kev pab cuam uas tsim nyog los mus muab cov ntaub ntawv qhia paub nyob rau cov qauv uas nkag siv tau dawb thiab. Hu rau 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ໝາຍເຫດ: ການບໍລິການທາງດ້ານພາສາມ່ນຝຣິຜົມໃຫ້ບໍລິການຕະຫຼາມ. ນອກນັ້ນ, ຍັງມີການບໍລິການຊ່ວຍເຫຼືອ ພວມມື້ນ ການບໍລິການສືມທີ່ເຫັນຈະສົມເຜົ່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ທ່ານເຂົ້າເຖິງໄດ້ຝຣິອິກນຳ. ໂທ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

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ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в других форматах также можно получить бесплатно. Позвоните по номеру 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

FIIRO GAAR AH: Haddii aad ku hadasho Af-Soomaali, adeegyada caawimaada luuqadda ee bilaashka ah ayaa laguu heli karaa. Kaalmooyinka iyo adeegyada dheeraadka ah ee kugu habboon si maclummaadka laguugu siyo qaabab la isticmaali karo ayaa sidoo kale laguu heli karaa weliba si lacag la'aan ah. Wac 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También disponemos de ayudas y servicios auxiliares adecuados de forma gratuita para facilitar información en formatos accesibles. Llame al 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga libreng serbisyo ng tulong sa wika. Mayroon ding mga naaangkop na karagdagang pantulong at serbisyo para makapagbigay ng impormasyon sa mga accessible na format na magagamit nang libre. Tumawag sa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Ngoài ra, cũng có sẵn các hỗ trợ và dịch vụ phụ trợ thích hợp miễn phí nhằm cung cấp thông tin ở các định dạng có thể truy cập. Gọi 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of Aspirus Health Plan Elite (PPO)

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

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

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

For questions about this document, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

This plan, Aspirus Health Plan Elite, is offered by Aspirus Health Plan, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Aspirus Health Plan, Inc. When it says “plan” or “our plan,” it means Aspirus Health Plan Elite.)

You can get this information for free in other formats, such as large print, braille, or audio. Call Customer Service at the number on the back cover of this document.

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

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

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CHAPTER 1

Get started as a member

SECTION 1 You're a member of Aspirus Health Plan Elite

Section 1.1	You're enrolled in Aspirus Health Plan Elite, which is a Medicare PPO
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You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Aspirus Health Plan Elite. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Aspirus Health Plan Elite is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with you about how Aspirus Health Plan Elite covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders or amendments*.

The contract is in effect for the months you're enrolled in Aspirus Health Plan Elite between January 1, 2026, and December 31, 2026.

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

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

SECTION 2 Plan eligibility requirements

Section 2.1	Eligibility requirements
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You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.

Chapter 1. Get started as a member

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

Section 2.2 Plan service area for Aspirus Health Plan Elite

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

Our service area includes these counties in Wisconsin: Adams, Clark, Columbia, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Sauk, Shawano, Taylor, Vilas, Waupaca, Waushara and Wood

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1.800.772.1213 (TTY users call 1.800.325.0778).

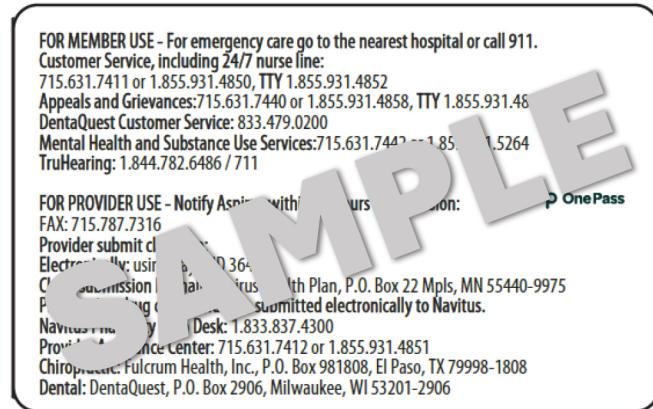
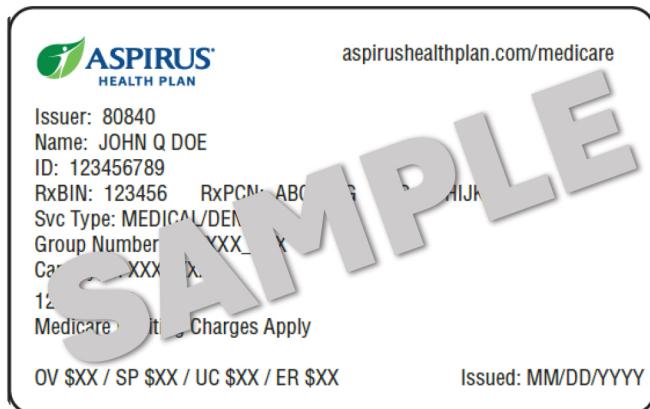
Section 2.3 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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



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

If our plan membership card is damaged, lost, or stolen, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8am - 8pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) right away and we'll send you a new card.

Section 3.2 Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* at search.aspirushealthplan.com lists our current network providers, pharmacies and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network

Chapter 1. Get started as a member

provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

Get the most recent list of providers and suppliers on our website at search.aspirushealthplan.com.

If you don't have a *Provider and Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Customer Services at 715.631.7411 or 1.855.931.4850 (this call is free), 8am - 8pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). Requested paper *Provider and Pharmacy Directories* will be mailed to you within 3 business days. You can also find this information on our website at search.aspirushealthplan.com, or download it from medicare.aspirushealthplan.com/member-resources. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Summary of Important Costs

Your cost in 2026	
Monthly plan premium*	\$0
*Your premium can be higher than this amount. Go to Section 4.1 for details.	
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for covered Part A and Part B services. Go to Chapter 4 Section 1 for details.)	From in-network providers: \$3,200 From in-network and out-of-network providers combined: \$3,200
Primary care office visits	In-network: \$0 copayment per visit Out-of-network: \$0 copayment per visit

Chapter 1. Get started as a member

Your cost in 2026	
Specialist office visits	In-network: \$45 copayment per visit Out-of-network: \$45 copayment per visit
Inpatient hospital stays	In-network: \$300 copayment for each Medicare-covered hospital stay until discharge. Out-of-network: 30% coinsurance

Your costs can include the following:

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

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Aspirus Health Plan Elite.

Section 4.2 Monthly Medicare Part B Premium**Many members are required to pay other Medicare premiums**

Your Medicare Part B premium is either automatically taken from your monthly Social Security check or you are billed directly. While you're a member of this Aspirus Health Medicare Advantage Plan, we'll pay up to \$25 of your Medicare Part B premium. You don't have to do anything to get this benefit. It could take a few months for this benefit to process.

- If your Medicare Part B premium is automatically taken from your monthly Social Security check, your monthly Social Security check will go up by \$25. Any missed increases will be added to your next check once the process is complete.

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- If you are billed directly for your Medicare Part B premium, your monthly premium bill will decrease by \$25. Any missed reductions will be reduced from your next bill once the process is complete.

If you leave this plan, your Medicare Part B premium reduction benefit will end on your last day as a member. Please note that it may take a few of months for this to process. Any premium reductions you get after you leave this plan will eventually be taken from your Social Security check if you are receiving Social Security or be added to your Part B Premium bill if you are billed directly.

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

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details. Aspirus Health Plan Elite members have the option of purchasing the Choice Dental benefit package. The monthly premium for this optional supplemental benefit is \$29. If you have any questions about your plan premiums, please call Customer Service.

SECTION 5 More information about your monthly plan premium

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

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

SECTION 6 Keep our plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). You may update your address, phone number, and email communication preferences by logging in to your online member account at medicare.aspirushealthplan.com/member-login. Using your online member account, you can also send us a message to request that we update your Primary Care Clinic selection.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1.800.772.1213 (TTY users call 1.800.325.0778).

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first ("the primary payer") pays up to the limits of its coverage. The insurance that pays second

Chapter 1. Get started as a member

(“secondary payer”) only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

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

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

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

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

CHAPTER 2

*Phone numbers
and resources*

SECTION 1 Aspirus Health Plan Elite contacts

For help with claims, billing, or member card questions, call or write to Aspirus Health Plan Elite Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free). TTY users call 715.631.7413 or 1.855.931.4852 (this call is free). We'll be happy to help you.

Customer Service - Contact Information	
Call	715.631.7411 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties hearing or speaking.
Fax	715.787.7322
Write	Attn: Customer Service Aspirus Health Plan PO Box 51 Minneapolis, MN 55440-9972
Website	medicare.aspirushealthplan.com

Chapter 2. Phone numbers and resources

How to ask 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 pay for your medical services. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions for Medical Care – Contact Information	
Call	Customer Service 715.631.7411 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties hearing or speaking.
Fax	715.631.7439 1.855.931.4857 Attn: Appeals and Grievances
Write	Attn: Standard Review Aspirus Health Plan PO Box 51 Minneapolis, MN 55440-9972
Website	medicare.aspirushealthplan.com

Chapter 2. Phone numbers and resources**How to make an appeal about your medical care**

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

Appeals for Medical Care – Contact Information	
Call	Appeals and Grievances 715.631.7440 1.855.931.4858 (this call is free) 8 am – 4:30 pm, Monday – Friday
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 4:30 pm, Monday – Friday These numbers require special telephone equipment and are only for people who have difficulties hearing or speaking.
Fax	715.631.7439 1.855.931.4857 Attn: Appeals and Grievances
Write	Attn: Appeals and Grievances Aspirus Health Plan PO Box 51 Minneapolis, MN 55440-9972 Or email us at cagMA@aspirushealthplan.com
Website	medicare.aspirushealthplan.com

Chapter 2. Phone numbers and resources

How to make a complaint about your medical care

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

Complaints About Medical Care – Contact Information	
Call	Customer Service 715.631.7411 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties hearing or speaking.
Fax	715.631.7439 1.855.931.4857 Attn: Appeals and Grievances
Write	Attn: Appeals and Grievances Aspirus Health Plan PO Box 51 Minneapolis, MN 55440-9972 Or email us at cagMA@aspirushealthplan.com
Medicare Website	To submit a complaint about Aspirus Health Plan Elite directly to Medicare, go to www.medicare.gov/my/medicare-complaint

Chapter 2. Phone numbers and resources

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

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

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

Payment Requests - Contact Information	
Call	Customer Service 715.631.7411 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties hearing or speaking.
Fax	715.787.7307
Write	Aspirus Health Plan Attn: Claims PO Box 51 Minneapolis, MN 55440
Website	medicare.aspirushealthplan.com

SECTION 2 Get help from Medicare

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

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

Chapter 2. Phone numbers and resources

Medicare - Contact Information	
Call	1.800.MEDICARE (1.800.633.4227) (This call is 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 hearing or speaking. (This call is free.)
Chat Live	Chat live at www.Medicare.gov/talk-to-someone
Write	Medicare PO Box 1270 Lawrence, KS 66044
Website	www.Medicare.gov <ul style="list-style-type: none">• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.• Find Medicare-participating doctors or other health care providers and suppliers.• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).• Get Medicare appeals information and forms.• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.• Look up helpful websites and phone numbers. <p>You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Aspirus Health Plan Elite:</p> <ul style="list-style-type: none">• To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Wisconsin, the SHIP is called State of Wisconsin - Board on Aging & Long Term Care (BOALTC).

State of Wisconsin - Board on Aging & Long Term Care is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State of Wisconsin - Board on Aging & Long Term Care counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. State of Wisconsin - Board on Aging & Long Term Care counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

State of Wisconsin - Board on Aging & Long Term Care – Contact Information	
Call	1.800.242.1060 (this call is free)
TTY	Call the Wisconsin Relay Service at 711 or use your preferred relay service. (This call is free.)
Write	State of Wisconsin - Board on Aging & Long Term Care 1402 Pankratz Street, Suite 111 Madison, Wisconsin 53704-4001
Website	longtermcare.wi.gov

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Commence Health in any of these situations:

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

Commence Health (Wisconsin's Quality Improvement Organization) – Contact Information	
Call	1.888.524.9900 (this call is free) 9 am – 5 pm, Monday – Friday 10 am – 4 pm on Weekends/Holidays
TTY	To use the service, individuals with hearing or speech disabilities who use teletypewriter (TTY) machines can dial 7-1-1 from anywhere in the United States to make outbound calls.
Fax	1.855.236.2423
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	www.livantaqio.com

Chapter 2. Phone numbers and resources

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security - Contact Information	
Call	1.800.772.1213 (This call is free.) Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (This call is free.) Available 8 am to 7 pm, Monday through Friday.
Website	www.ssa.gov

SECTION 6 Medicaid

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

Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

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

Chapter 2. Phone numbers and resources

Wisconsin Department of Health Services – Contact Information	
Call	608.266.1865
TTY	1.800.947.3529 (this call is free) This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Department of Health Services 1 West Wilson Street Madison, WI 53703
Website	www.dhs.wisconsin.gov/medicaid

SECTION 7 Railroad Retirement Board (RRB)

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

Railroad Retirement Board - Contact Information	
Call	1.877.772.5772 (This call is free.) Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1.312.751.4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	http://RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1.800.MEDICARE (1.800.633.4227) with questions about your Medicare coverage under this plan. TTY users call 1.877.486.2048.

CHAPTER 3

*Using our plan for
your medical services*

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, Aspirus Health Plan Elite must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Aspirus Health Plan Elite will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).

Chapter 3. Using our plan for your medical services

- The providers in our network are listed in the *Provider and Pharmacy Directory* at search.aspirushealthplan.com.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- Note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care
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What is a PCP and what does the PCP do for you?

A PCP is a provider who knows you and your medical history. Your PCP is trained to give you basic medical care. When you become a member of the plan, you must choose a Primary Care Clinic. A Primary Care Clinic is a clinic within Aspirus Health Plan Elite's network. You can see any PCP at this clinic. The types of providers that can act as a PCP are family medicine doctors, general practitioners, internists, geriatricians, doctors in obstetrics/gynecology, nurse midwives, physician assistants and nurse practitioners. You can get your routine or basic care from your PCP who will also coordinate the rest of the covered services you get as a plan member. This includes but is not limited to:

- Diagnostic tests
- X-rays
- Laboratory tests
- Therapies
- Hospital admissions
- Follow-up care
- Care from doctors who are specialists (you do not need a referral to see an in-network specialist)

Chapter 3. Using our plan for your medical services

“Coordinating” your services includes checking or consulting with other network providers about your care and how it is going. Some services will need prior authorization (see Chapter 4 for details). Because your provider will coordinate your medical care, you should have all of your past medical records sent to your provider’s office. Chapter 6 tells you how we protect the privacy of your medical records and personal health information.

How to choose a PCP?

When you become a member of Aspirus Health Plan Elite, you choose or are assigned a Primary Care Clinic (PCC). You can use any provider in this PCC as your PCP. You can change your PCC at any time.

How to change your PCP

You can change your PCP for any reason, at any time. It’s also possible that your PCP might leave our plan’s network of providers, and you’d need to choose a new PCP or you’ll pay more for covered services. If we are notified that your clinic is leaving the network, we will notify you in writing.

When you change your PCP, it may take 10-14 business days for the change to take effect. To change your provider or clinic, call Customer Service.

Section 2.2 Medical care you can get without a PCP referral

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

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

Chapter 3. Using our plan for your medical services

service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never exceed the cost sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider that is outside our plan's network, your cost sharing can't exceed the cost sharing you pay in-network.

However, if your usual in-network provider for dialysis is available and you choose to get services inside the service area from a provider outside our plan's network, the cost sharing for the dialysis may be higher.

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

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

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

You can see any specialist in the network on your own without a referral. To see an **out-of-network** doctor or specialist, your provider must obtain prior authorization from us in order for those services to be covered at the **in-network** cost-sharing level.

When a specialist or another network provider leaves our plan?

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

Chapter 3. Using our plan for your medical services

- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. You may need a prior authorization to get in-network cost-sharing.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. **However, if you use an out-of-network provider, your share of the costs for covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 7, Section 4). This is important because:
 - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal).

Chapter 3. Using our plan for your medical services

- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

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

Covered services in a medical emergency

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

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

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

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

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

You can find a list of urgent care providers online at search.aspirushealthplan.com, or by calling Customer Service at the number on the back cover of this booklet. To find out how to access urgently needed care, you can call your provider, or call the Aspirus Health Plan 24/7 Nurse Line at 1.833.968.1769 (this call is free), 24 hours a day, seven days a week; TTY: 1.855.931.4852 (this call is free), 24 hours a day, seven days a week. The nurse line can give you information on how to access care after normal business hours.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances. If you have an emergency or an urgent need for care outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf.

We'll pay you back (or will pay the provider if they submit the claim) at rates no greater than the rates at which Original Medicare would pay, had the services been performed in the locality where you live in the U.S. We'll subtract any cost-sharing amount you owe from the amount we pay. The amount we pay may be less than the amount you pay the foreign provider. This is because we'll pay at rates no greater than what Original Medicare would pay, and because foreign providers might charge more for services than the rates at which Original Medicare would pay. Because of this, you may want to consider purchasing travel insurance when you are planning to travel outside of the United States.

Chapter 3. Using our plan for your medical services

Worldwide emergency and urgent care services are a supplemental benefit not generally covered by Medicare. You must send proof of payment to Aspirus Health Plan so we can pay you back. Go to Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) for more information. If you've already paid for the covered services, we'll pay you back for our share of the cost. You can send the bill with medical records to us for payment consideration. 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 if you get a bill or if you need to ask us to pay you back.

Section 3.3 Get care during a disaster

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

Visit medicare.aspirushealthplan.com for information on how to get needed care during a disaster.

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

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

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

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

Aspirus Health Plan Elite covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. For services with a benefit limit, any additional cost beyond the benefit limit will not count toward your out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

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

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at:

www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.

You can also call 1.800.MEDICARE (1.800.633.4227) TTY users call 1.877.486.2048.

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

Section 6.1 A religious non-medical health care institution

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

Chapter 3. Using our plan for your medical services

care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

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

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. For more information, see "Inpatient hospital care" in the Medical Benefits Chart in Chapter 4 of this document.

SECTION 7 Rules for ownership of durable medical equipment

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

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

Chapter 3. Using our plan for your medical services

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 Aspirus Health Plan Elite, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) for more information.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Aspirus Health Plan Elite 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 Aspirus Health Plan Elite or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4

Medical Benefits Chart

(what's covered and what you pay)

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

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

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

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

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

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

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

Under our plan, there are 2 different limits on what you pay out of pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is \$3,200. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with a checkmark in the Medical Benefits Chart.) If you pay \$3,200 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

- Your **combined maximum out-of-pocket amount** is \$3,200. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with a checkmark in the Medical Benefits Chart.) If you pay \$3,200 for covered services, you will have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you go to:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- If you think a provider has balance billed you, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

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

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

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
 - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the Medical Benefits Chart. These services not listed in the Medical Benefits Chart require approval in advance: inpatient rehabilitation services, spine surgery, bone growth stimulators, spinal cord stimulators, and molecular/genetic testing (for example – screening for cancer).
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:

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

- If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
- If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay less. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2026 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

Important Benefit Information for People Who Qualify for Extra Help

- If you get Extra Help to pay your Medicare drug program costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.



This apple shows preventive services in the Medical Benefits Chart.

* You will see this asterisk next to services that may require a prior authorization.

✓ You will see this checkmark next to services that do not apply to your out-of-pocket maximum.

Medical Benefits Chart

You may be responsible for more than one cost share (copayment or coinsurance) payment if more than one service is provided at an appointment. Examples:

- Copayment for the office visit and additional cost share for diagnostic tests (including x-rays) performed while you are there.

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

- The hospital will ask for separate cost sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there.
- The specific cost sharing depends on which services you receive. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	\$45 copayment for each Medicare-covered visit.	\$45 copayment for each Medicare-covered visit.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Acupuncture for chronic low back pain (continued)</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none">• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Ambulance services</p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p> <p>Aspirus Health Plan follows Original Medicare. Original Medicare doesn't cover ambulance services if you're not transported. This means that we won't pay for ambulance services, including treatment performed, if one is dispatched for you and you're not transported.</p> <p>When multiple ground and/or air ambulance providers respond, we only pay for the ambulance provider that transports you.</p>	<p>\$200 copayment for each one-way Medicare-covered trip.</p>	<p>\$200 copayment for each one-way Medicare-covered trip.</p>
<p> Annual physical exam</p> <p>In addition to the Annual Wellness Visit or the "Welcome to Medicare" preventive visit, you are covered for the following, once per calendar year:</p>	<p>There is no coinsurance, copayment, or deductible for the</p>	<p>30% coinsurance for this annual physical exam.</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Annual physical exam (continued) <ul style="list-style-type: none">Comprehensive preventive medicine evaluation including examination, and counseling/anticipatory guidance/risk factor reduction interventions. <p>Note: Doesn't include lab or diagnostic tests (ex: x-rays, blood tests, MRIs, etc). Additional copayments or coinsurance may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart.</p>	annual physical exam.	
 Annual wellness visit <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	There is no coinsurance, copayment, or deductible for the annual wellness visit.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
 Bone mass measurement <p>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more</p>	There is no coinsurance, copayment, or deductible for	There is no coinsurance, copayment, or deductible for

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Bone mass measurement (continued) frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Medicare-covered bone mass measurement.	Medicare-covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	There is no coinsurance, copayment, or deductible for covered screening mammograms.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
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. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	\$40 copayment for each Medicare-covered visit.	30% coinsurance for each Medicare-covered visit.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 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, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 24 months If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Chiropractic services* Covered services include: <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	\$20 copayment for each Medicare-covered visit.	30% coinsurance for each Medicare-covered visit.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Refer to the following rows found in this Medical Benefits Chart: “Acupuncture for chronic low back pain” “Chiropractic services” “Medicare Part B drugs” “Opioid treatment program services” “Outpatient mental health care” “Outpatient rehabilitation services”	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Refer to the following rows found in this Medical Benefits Chart: “Acupuncture for chronic low back pain” “Chiropractic services” “Medicare Part B drugs” “Opioid treatment program services” “Outpatient mental health care” “Outpatient rehabilitation services”

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Colorectal cancer screening</p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.</p>	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Colorectal cancer screening (continued)</p> <p>colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography.</p> <ul style="list-style-type: none">• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.</p>	<p>\$0 copayment for Medicare-covered dental services.</p> <p>There may be additional facility services copayment/coinsurance.</p> <p>Refer to the "Outpatient hospital services" row in this Medical Benefits Chart.</p> <p>There may also be additional copayment/coinsurance from other categories.</p> <p>Refer to the following rows found in this Medical Benefits Chart:</p> <p>"Inpatient hospital care"</p> <p>"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"</p> <p>"Outpatient diagnostic tests and</p>	<p>30% coinsurance for Medicare-covered dental services.</p> <p>There may be additional facility services copayment/coinsurance.</p> <p>Refer to the "Outpatient hospital services" row in this Medical Benefits Chart.</p> <p>There may also be additional copayment/coinsurance from other categories.</p> <p>Refer to the following rows found in this Medical Benefits Chart:</p> <p>"Inpatient hospital care"</p> <p>"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"</p> <p>"Outpatient diagnostic tests and</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Dental services (continued)	therapeutic services and supplies" "Prosthetic and orthotic devices and related supplies"	therapeutic services and supplies" "Prosthetic and orthotic devices and related supplies"
In addition, we cover:		
Preventive dental services <ul style="list-style-type: none"> • Oral examination: 1 every year • Routine cleaning of teeth: 1 every year • Periodontal (gum) maintenance cleaning: 1 every year • X-rays: 1 - 4 bitewing x-rays (one set of up to 4 films) – once every calendar year • Topical application of fluoride in conjunction with a routine cleaning, or topical fluoride varnish application in conjunction with a routine dental examination, as deemed necessary by a dental provider. 	\$0 copayment per visit for all plan-covered preventive dental services, including periodontal maintenance.	\$0 copayment per visit for all plan-covered preventive dental services, including periodontal maintenance.✓
You must see a DentaQuest network dentist of your choice to receive this benefit at the in-network benefit level.		
If your dental services are performed by a dentist outside of the DentaQuest network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and the Aspirus Health Plan dental fee schedule.		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Dental services (continued)</p> <p>If the dental provider is unable to submit the claim on your behalf, it should be submitted to:</p> <p>DentaQuest PO Box 2906 Milwaukee, WI 53201-2906</p> <p>Comprehensive dental services are available under the optional supplemental rider option and additional dental benefit details can be found online at medicare.aspirushealthplan.com/member-resources.</p> <p>If you have questions about your dental plan, call DentaQuest customer service at 1.833.479.0200 (this call is free), 8 am – 5 pm, Monday – Friday, or call the TTY line at 711 (this call is free). You can also call Aspirus Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week, or call the TTY line at 715.631.7413 or 1.855.931.4852 (this call is free).</p>		
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Diabetes screening <p>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>
 Diabetes self-management training, diabetic services, and supplies <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized 	<p>20% coinsurance for each Medicare-covered diabetes monitoring supply (includes continuous glucose monitor).</p> <p>Coverage is limited to specific manufacturer brands.</p> <p>20% coinsurance for each Medicare-covered pair of therapeutic shoes or inserts.</p>	<p>30% coinsurance for each Medicare-covered diabetes monitoring supply (includes continuous glucose monitor).</p> <p>Coverage is limited to specific manufacturer brands.</p> <p>30% coinsurance for each Medicare-covered pair of therapeutic shoes or inserts.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Diabetes self-management training, diabetic services, and supplies (continued) <ul style="list-style-type: none"> removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. 	\$0 copayment for Medicare-covered diabetes self-management training.	30% coinsurance for Medicare-covered diabetes self-management training.
Durable medical equipment (DME) and related supplies* <p>(For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.)</p> <p>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at search.aspirushealthplan.com.</p>	20% coinsurance for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits.

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.</p> <p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p>	<p>\$130 copayment for each emergency room visit.</p> <p>You do not pay this amount if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition.</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost sharing amount for the part of your stay after you're stabilized.</p>	<p>\$130 copayment for each emergency room visit.</p> <p>You do not pay this amount if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition.</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital to pay the in-network cost sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost sharing amount for the part of your stay after you're stabilized.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Emergency care (continued)		
	See “Inpatient hospital care” in this benefits chart for information on inpatient hospital cost sharing.	See “Inpatient hospital care” in this benefits chart for information on inpatient hospital cost sharing.
<u>Worldwide emergency care:</u> Worldwide emergency care applies to emergency care outside the United States and its territories.	\$130 copayment for each worldwide emergency care visit. ✓	\$130 copayment for each worldwide emergency care visit. ✓
<p>Coverage includes:</p> <ul style="list-style-type: none"> Emergency care: Services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition, as well as services provided after stabilization and provided to maintain the condition. Post-stabilization services end at discharge. Ground ambulance for emergency transportation to the nearest appropriate hospital for emergency care. Air ambulance (fixed wing or rotary wing) is not covered. <p>Transportation back to the United States or its territories is also not covered.</p> <p>If you have an emergency outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf. Go to Chapter 5,</p>	\$100 copayment for each one-way worldwide ground emergency transportation. ✓	\$100 copayment for each one-way worldwide ground emergency transportation. ✓

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Emergency care (continued) Section 2 for information on how to get paid back for medical services.		
E-visits In addition to in-person doctor's office visits, Aspirus Health Plan Elite covers E-visits at no charge when you use Virtuwell® at virtuwell.com . Virtuwell® provides online diagnosis and treatment for minor conditions (e.g., allergies, sinus infections, rashes) 24 hours a day, seven days a week, without an appointment. Be sure to create an account and provide your insurance information at the time of your online visit. Go to Chapter 10 for definitions of E-visit and Virtuwell®. (Note: Use of online clinics is optional. You can continue going to your provider directly.)	\$0 copayment for each E-visit.	\$0 copayment for each E-visit.
 Health and wellness education programs Aspirus Health Plan offers many programs to help you stay healthy. For the most up to date information on these programs, log in or create an online member account at medicare.aspirushealthplan.com/member-login . You may also call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week. For TTY, call 715.631.7413 or 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week.		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Health and wellness education programs (continued) Strong and Stable Kit Tools to help you stay strong and prevent falls. If you'd like to order the kit, contact Customer Service at the number on the back of your member ID card or log into your online member account at medicare.aspirushealthplan.com/member-login . Note: Must be an eligible Aspirus Health Plan member at the time of the order. Limit one kit per year per member. Kit contents may be subject to change. Please allow 4 – 6 weeks for delivery.	\$0 copayment	\$0 copayment
One Pass A complete fitness solution giving you access to: <ul style="list-style-type: none"> • a large network of fitness locations nationwide • on-demand and live-streaming fitness classes • workout builders to help you create your own workouts and walk you through each exercise • Home Fitness Kits available upon request (one kit per year) • online personalized brain-training program to help improve memory, attention and focus • online or in-person social activities, community classes and events For more information, visit medicare.aspirushealthplan.com/ahp_onepass	\$0 copayment	\$0 copayment

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Health and wellness education programs (continued)</p> <p>or call 1.877.504.6830 or for TTY access use 711, 8 am – 9 pm, Monday – Friday.</p> <p>Aspirus Health Plan Healthy Benefits+ Visa® card</p> <p>A flexible and convenient way to access your eligible allowances, discounts and rewards. You will get a Healthy Benefits+ Visa® card when you join the plan. You will not get a new one each year. The card is valid until it expires or you are no longer a Aspirus Health Plan member. Allowance amounts and expiration dates vary by plan and program. The Healthy Benefits+ Visa® card won't work for international purchases.</p> <p>Download the Healthy Benefits+ app from the Apple App Store or Google Play™. Data fees may apply.</p> <p>The Healthy Benefits+ app includes:</p> <ul style="list-style-type: none">• The store finder• A digital card• Real-time access to your benefit balance and transaction history <p>To learn more, check your card balance or request a replacement card, visit healthybenefitsplus.com/aspirus or call 1.833.862.8276 (this call is free); TTY 711 (this call is free). This phone number is also on the back of your Healthy Benefits+ Visa® card.</p>	There is no cost for this card.	There is no cost for this card.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Health and wellness education programs (continued)		
Grocery Discounts Discounts on pre-qualified healthy foods such as milk, whole-grain bread, lean meat, eggs, yogurt, fruits, vegetables and more. Weekly discounts are loaded to your Healthy Benefits+ Visa® card. Scan your card when paying at participating stores to get the discount.	There is no cost to use this discount at participating stores.	There is no cost to use this discount at participating stores.
Aspirus Health Plan 24/7 Nurse Line Access to medical and health information 24 hours a day, 7 days a week, including weekends and holidays. Call 1.833.968.1769 (this call is free) or TTY: 1.855.931.4852 (this call is free).	There is no cost for this service.	There is no cost for this service.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We offer additional supplemental hearing services through TruHearing. Coverage includes: <ul style="list-style-type: none"> • Routine hearing exam: 1 every year • Fittings and evaluations for prescription hearing aids: unlimited 	\$40 copayment for each Medicare-covered visit. \$0 copayment for one routine hearing exam every year. \$0 copayment for hearing aid fittings and evaluations.	30% coinsurance for each Medicare-covered visit. 30% coinsurance for one routine hearing exam every year. 30% coinsurance for hearing aid fittings and evaluations.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Hearing services (continued)		
<ul style="list-style-type: none"> Prescription hearing aids: up to 2 TruHearing-branded hearing aids every year <ul style="list-style-type: none"> Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors Prescription hearing aids are available for 2 different copay amounts for Advanced and Premium models No additional cost per aid for optional hearing aid rechargeability on some Premium aid styles 	<p>\$899 copayment per aid for Premium Aids ✓</p> <p>Benefits are combined in and out-of-network — hearing aids must come from TruHearing for these copays to apply.</p>	<p>\$899 copayment per aid for Premium Aids ✓</p> <p>Benefits are combined in and out-of-network — hearing aids must come from TruHearing for these copays to apply.</p>
How to access hearing aid benefits:		
<ul style="list-style-type: none"> The benefit is only available through TruHearing. For more information on covered prescription hearing aids or to schedule an appointment with a TruHearing provider, call 1.844.782.6486 (for TTY, dial 711), 8 am – 8 pm, Monday – Friday. 		
For general information about TruHearing benefits visit: <a ghost"="" href="http://TruHearing.com>Select.</td><td data-kind=">		
Help with Certain Chronic Conditions*		
<p>Home delivered meal benefit for members with congestive heart failure who have been discharged from the hospital. If you are eligible for this benefit, we will contact you after you have been discharged.</p> <ul style="list-style-type: none"> 28 home delivered meals for 14 days 	\$0 copayment	\$0 copayment

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Help with Certain Chronic Conditions* (continued)</p> <ul style="list-style-type: none"> • 2 meals per day 		
<p> HIV screening</p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months. <p>If you are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to 3 screening exams during a pregnancy. 	<p>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>	<p>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care*</p> <p>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services 	<p>\$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.</p> <p>There is cost sharing for durable medical equipment and related supplies. Please refer to "Durable medical equipment and related supplies."</p>	<p>30% coinsurance for all home health visits provided by an out-of-network home health agency when Medicare criteria are met.</p> <p>For durable medical equipment and related supplies, please refer to "Durable medical equipment and related supplies."</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Home health agency care* (continued) <ul style="list-style-type: none"> Medical equipment and supplies 		
Home infusion therapy <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with our plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier 	These services will be covered as described in the following sections found in this Medical Benefits Chart: Please refer to “Physician/Practitioner services, including doctor's office visits,” “Durable medical equipment (DME) and related supplies” and “Medicare Part B drugs.”	These services will be covered as described in the following sections found in this Medical Benefits Chart: Please refer to “Physician/Practitioner services, including doctor's office visits,” “Durable medical equipment (DME) and related supplies” and “Medicare Part B drugs.”
Hospice care <p>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice</p>	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Hospice care (continued)</p> <p>program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you're admitted to a hospice you have the right to stay in our plan.</p> <p>For hospice services and services that are covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow</p>	<p>your terminal prognosis are paid for by Original Medicare, not Aspirus Health Plan Elite.</p>	<p>your terminal prognosis are paid for by Original Medicare, not Aspirus Health Plan Elite.</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Hospice care (continued)</p> <p>plan rules (like if there's a requirement to get prior authorization).</p> <ul style="list-style-type: none">• If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services• If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <p>For services covered by Aspirus Health Plan Elite but not covered by Medicare</p> <p>Part A or B: Aspirus Health Plan Elite will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Immunizations <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B and COVID-19 vaccines.</p> <p>Refer to "Medicare Part B drugs" in this Medical Benefits Chart.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B and COVID-19 vaccines.</p> <p>Refer to "Medicare Part B drugs" in this Medical Benefits Chart.</p>
Inpatient hospital care* <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies 	<p>\$300 copayment for each Medicare-covered hospital stay until discharge.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.</p> <p>For inpatient hospital care, the cost sharing described above applies each time</p>	<p>30% coinsurance for each Medicare-covered hospital stay until discharge.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital.</p> <p>For inpatient hospital care, the cost sharing described above applies each time</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient hospital care* (continued)		
<ul style="list-style-type: none"> • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. 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 Aspirus Health Plan Elite provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood that you need. All other components of blood are covered starting with the first pint. • Physician services 	<p>you are admitted to the hospital.</p> <p>For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered.</p> <p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p>	<p>you are admitted to the hospital.</p> <p>For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered.</p> <p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Inpatient hospital care* (continued)</p> <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048.</p>		
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day lifetime limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</p>	<p>\$300 copayment for each Medicare-covered hospital stay until discharge. Each Medicare-covered hospital stay is limited to 90 days. Plus an additional 60 lifetime reserve days.</p> <p>For inpatient hospital care, the cost sharing described above applies each time</p>	<p>30% coinsurance for each Medicare-covered hospital stay until discharge. Each Medicare-covered hospital stay is limited to 90 days. Plus an additional 60 lifetime reserve days.</p> <p>For inpatient hospital care, the cost sharing described above applies each time</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Inpatient services in a psychiatric hospital (continued)	<p>you are admitted to the hospital.</p> <p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p>	<p>you are admitted to the hospital.</p> <p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long-Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p>
Inpatient stay: covered services you get in a hospital or SNF during a non-covered inpatient stay <p>If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) 	<p>When your stay is no longer covered, these services will be covered as described in the following sections found in this Medical Benefits Chart:</p> <p>“Physician/Practitioner</p>	<p>When your stay is no longer covered, these services will be covered as described in the following sections found in this Medical Benefits Chart:</p> <p>“Physician/Practitioner</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Inpatient stay: covered services you get in a hospital or SNF during a non-covered inpatient stay (continued)</p> <ul style="list-style-type: none"> • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p>services, including doctor's office visits”</p> <p>“Outpatient diagnostic tests and therapeutic services and supplies”</p> <p>“Prosthetic and orthotic devices and related supplies”</p> <p>“Outpatient rehabilitation services”</p>	<p>services, including doctor's office visits”</p> <p>“Outpatient diagnostic tests and therapeutic services and supplies”</p> <p>“Prosthetic and orthotic devices and related supplies”</p> <p>“Outpatient rehabilitation services”</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Medical nutrition therapy (continued) Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.		
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people 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, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services 	20% coinsurance for each Medicare-covered Part B drug. \$35 copayment for each Medicare-covered Part B insulin drug. You will not pay more than \$35 for a one-month supply of	20% coinsurance for each Medicare-covered Part B drug. \$35 copayment for each Medicare-covered Part B insulin drug. You will not pay more than \$35 for a one-month supply of

Covered Service	What you pay In-Network	What you pay Out-of-Network
Medicare Part B drugs* (continued)		
<ul style="list-style-type: none"> • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare (Part D) drug coverage covers immunosuppressive drugs if Part B doesn't cover them. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens (allergy shots): Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision 	Part B insulin. Deductibles do not apply. Additionally, for the administration of that drug, you will pay the cost sharing that applies to primary care provider services or specialist services (as described under "Physician/Practitioner services, including doctor's office visits" in this benefit chart). 20% coinsurance for each Medicare-covered Part B chemotherapy drug and the administration of that drug. Certain drugs may have a lower coinsurance.	Part B insulin. Deductibles do not apply. Additionally, for the administration of that drug, you will pay the cost sharing that applies to primary care provider services or specialist services (as described under "Physician/Practitioner services, including doctor's office visits" in this benefit chart). 20% coinsurance for each Medicare-covered Part B chemotherapy drug and the administration of that drug. Certain drugs may have a lower coinsurance.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Medicare Part B drugs* (continued)		
<ul style="list-style-type: none">• Certain oral anti-cancer drugs : Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does.• Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®• Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics• Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®,		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Medicare Part B drugs* (continued)</p> <p>Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta)</p> <ul style="list-style-type: none">• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases• Parenteral and enteral nutrition (intravenous and tube feeding) <p>This link will take you to a list of Part B drugs that may be subject to Step Therapy: medicare.aspirushealthplan.com/drug-list-search.</p> <p>We also cover some vaccines under our Part B drug benefit.</p>		
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>\$0 copayment for each Medicare-covered opioid treatment program service.</p>	<p>30% coinsurance for each Medicare-covered opioid treatment program service.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • X-rays 	<p>\$30 copayment for each Medicare-covered standard x-ray service.</p>	<p>30% coinsurance for each Medicare-covered standard x-ray service.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies (continued)		
<ul style="list-style-type: none"> • Radiation (radium and isotope) therapy including technician materials and supplies 	<p>20% coinsurance for each Medicare-covered radiation (radium and isotope) therapy service, including technician materials and supplies.</p>	<p>30% coinsurance for each Medicare-covered radiation (radium and isotope) therapy service, including technician materials and supplies.</p>
	<p>Your cost share for radiation therapy services in a single day will not exceed \$125.</p>	
<ul style="list-style-type: none"> • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. 	<p>20% coinsurance for each Medicare-covered diagnostic radiology service.</p>	<p>30% coinsurance for each Medicare-covered diagnostic radiology service.</p>
	<p>Your cost share for diagnostic radiology services in a single day will not exceed \$125.</p>	
<ul style="list-style-type: none"> • Diagnostic mammograms 	<p>0% coinsurance for each Medicare-covered diagnostic mammogram.</p>	<p>30% coinsurance for Medicare-covered diagnostic mammogram.</p>
<ul style="list-style-type: none"> • Other outpatient diagnostic tests 	<p>\$0 copayment for each Medicare-covered other diagnostic test.</p>	<p>30% coinsurance for each Medicare-covered other diagnostic test.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Outpatient diagnostic tests and therapeutic services and supplies (continued)</p> <ul style="list-style-type: none"> • 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, and all other components of blood are covered beginning with the first pint of blood that you need. 	<p>20% coinsurance for each Medicare-covered medical supply.</p> <p>\$0 copayment for each Medicare-covered laboratory test.</p> <p>\$0 copayment for Medicare-covered blood services.</p>	<p>30% coinsurance for each Medicare-covered medical supply.</p> <p>\$0 copayment for each Medicare-covered laboratory test.</p> <p>30% coinsurance for Medicare-covered blood services.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p>	<p>\$195 copayment for Medicare-covered outpatient hospital observation services included in a single stay.</p>	<p>30% coinsurance for Medicare-covered outpatient hospital observation services included in a single stay.</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Outpatient hospital observation (continued)</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048.</p>		
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it 	<p>\$195 copayment for each Medicare-covered outpatient hospital service, including observation, outpatient surgery or procedure.</p> <p>In addition, please refer to the following sections found in this Medical Benefits Chart:</p>	<p>30% coinsurance for each Medicare-covered outpatient hospital service, including observation, outpatient surgery or procedure.</p> <p>In addition, please refer to the following sections found in this Medical Benefits Chart:</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Outpatient hospital services (continued)</p> <ul style="list-style-type: none"> • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, ask the hospital staff.</p>	<p>“Emergency care” or “Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.”</p> <p>“Outpatient diagnostic tests and therapeutic services and supplies.”</p> <p>“Outpatient mental health care” or “Partial hospitalization services.”</p> <p>“Medicare Part B drugs.”</p>	<p>“Emergency care” or “Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.”</p> <p>“Outpatient diagnostic tests and therapeutic services and supplies.”</p> <p>“Outpatient mental health care” or “Partial hospitalization services.”</p> <p>“Medicare Part B drugs.”</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$0 copayment for each Medicare-covered visit.</p>	<p>\$0 copayment for each Medicare-covered visit.</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Outpatient rehabilitation services</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$40 copayment for each Medicare-covered visit.</p>	<p>\$40 copayment for each Medicare-covered visit.</p>
<p>Outpatient substance use disorder services</p> <p>Covered services include:</p> <p>Substance use disorder services provided in an outpatient hospital, community mental health center, federally qualified health center, rural health clinic, or opioid treatment program by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified health care professional as allowed under applicable state laws, and conducted under the supervision and direction of a physician.</p>	<p>\$0 copayment for each Medicare-covered visit.</p>	<p>\$0 copayment for each Medicare-covered visit.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider</p>	<p>\$195 copayment for each Medicare-covered outpatient surgery or</p>	<p>30% coinsurance for each Medicare-covered outpatient surgery or</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* (continued)</p> <p>writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	<p>procedure at an outpatient hospital facility or ambulatory surgical center.</p>	<p>procedure at an outpatient hospital facility or ambulatory surgical center.</p>
<p>Over-the-counter (OTC) allowance</p> <p>A \$75 allowance loaded onto your Healthy Benefits+ Visa® card every six months to buy non-prescription items such as cough drops, first aid supplies, pain relief, sinus medications, tooth paste and much more. Dollars you don't use will expire on June 30 and December 31 or upon plan termination. The Healthy Benefits+ Visa® card won't work for international purchases.</p> <p>Use your Healthy Benefits+ Visa® card to shop:</p> <ul style="list-style-type: none"> • in-store at participating retailers • online at HealthyBenefitsPlus.com/aspirus • over the phone at 1.833.862.8276 (TTY users call 711) • in the Healthy Benefits+ mobile app <p>Download the Healthy Benefits+ app from the Apple App Store or Google Play™ to</p>	<p>No cost share until the allowance limit is reached (combined in and out-of-network), then 100% of cost share is member responsibility.</p>	<p>No cost share until the allowance limit is reached (combined in and out-of-network), then 100% of cost share is member responsibility.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Over-the-counter (OTC) allowance (continued)</p> <p>have an easier shopping experience. Data fees may apply.</p> <p>The Healthy Benefits+ app includes:</p> <ul style="list-style-type: none"> • The store finder • a digital card • real-time access to your benefit balance and transaction history <p>To learn more, check your card balance or request a replacement card, visit HealthyBenefitsPlus.com/aspirus or call 1.833.862.8276 (this call is free); TTY 711 (this call is free). This phone number is also on the back of your Healthy Benefits+ Visa® card.</p>		
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a</p>	\$0 copayment for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Partial hospitalization services and Intensive outpatient services (continued)</p> <p>federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>		
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location Consultation, diagnosis, and treatment by a specialist Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment Certain telehealth services, including those for: <ul style="list-style-type: none"> Medicare-approved services, including urgently needed services, primary care provider and specialist visits, individual and group mental health sessions, podiatry services, diagnostic procedures and tests, dialysis services, kidney disease education services and eye exams You have the option of getting these services through an in-person visit 	<p>\$0 copayment for medical care furnished by a primary care provider. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules).</p> <p>\$45 copayment for services obtained from a specialist.</p> <p>NOTE: Medicare-covered telehealth services will be subject to the same cost sharing as services</p>	<p>\$0 copayment for medical care furnished by a primary care provider. Or, under certain circumstances, by a nurse practitioner or physician's assistant or other non-physician health care professionals (as permitted under Medicare rules).</p> <p>\$45 copayment for services obtained from a specialist.</p> <p>NOTE: Medicare-covered telehealth services will be subject to the same cost sharing as services</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <p>or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.</p> <ul style="list-style-type: none"> • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> - You have an in-person visit within 6 months prior to your first telehealth visit - You have an in-person visit every 12 months while getting these telehealth services - Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: 	<p>you would receive in-person. If you have surgery or procedures done in a certified ambulatory surgical center or hospital outpatient setting, see the "Outpatient surgery, including services provided at outpatient hospital facilities and ambulatory surgical centers" and/or the "Outpatient hospital services" sections in this benefits chart for applicable copayments or coinsurance amounts.</p>	<p>you would receive in-person. If you have surgery or procedures done in a certified ambulatory surgical center or hospital outpatient setting, see the "Outpatient surgery, including services provided at outpatient hospital facilities and ambulatory surgical centers" and/or the "Outpatient hospital services" sections in this benefits chart for applicable copayments or coinsurance amounts.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> - You're not a new patient and - The check-in isn't related to an office visit in the past 7 days and - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> - You're not a new patient and - The evaluation isn't related to an office visit in the past 7 days and - The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • In addition to in-person doctor's office visits, you have access to E-visits through Virtuwell®, available 24 hours a day, seven days a week without an appointment. <p>Go to the E-visits section of the Medical Benefits Chart and Chapter 10 for definitions of E-visit and Virtuwell®. (Note: Use of online clinics is optional. You can continue going to your provider directly.)</p>	\$0 copayment for each E-visit.	\$0 copayment for each E-visit.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs 	\$40 copayment for each Medicare-covered visit.	\$40 copayment for each Medicare-covered visit.
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention</p> <p>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. <p>A one-time hepatitis B virus screening.</p>	There is no coinsurance, copayment, or deductible for the PrEP benefit.	There is no coinsurance, copayment, or deductible for the PrEP benefit.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	There is no coinsurance, copayment, or deductible for an annual digital rectal exam and PSA test.	30% coinsurance for an annual Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail.	20% coinsurance for Medicare-covered prosthetic and orthotic devices, including repair and/or replacement. 20% coinsurance for Medicare-covered supplies.	30% coinsurance for Medicare-covered prosthetic and orthotic devices, including repair and/or replacement. 30% coinsurance for Medicare-covered supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic	\$20 copayment for each Medicare-covered visit.	30% coinsurance for each Medicare-covered visit.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Pulmonary rehabilitation services (continued)</p> <p>obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>		
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults (including pregnant people) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Screening for lung cancer with low dose computed tomography (LDCT) (continued)</p> <p>such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Screening for Hepatitis C Virus infection</p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant people and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued) behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.		
Services to treat kidney disease Covered services include: <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) 	\$0 copayment for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits. 20% coinsurance for Medicare-covered benefits received from an in-network provider in your service area or from any provider when you are temporarily outside the service area.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Services to treat kidney disease (continued)</p> <ul style="list-style-type: none"> • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to <i>Medicare Part B drugs</i> in this table.</p>	<p>Please refer to the "Inpatient hospital care" section found in this Medical Benefits Chart.</p> <p>20% coinsurance for Medicare-covered benefits.</p>	<p>Please refer to the "Inpatient hospital care" section found in this Medical Benefits Chart.</p> <p>20% coinsurance for Medicare-covered benefits.</p>
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.)</p> <p>No prior hospital stay is required. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.</p> <p>Covered services include but aren't limited to:</p>	<p>\$0 copayment for days 1- 20; \$218 copayment per day for days 21-43; \$0 copayment for days 44-100, per benefit period.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when</p>	<p>30% coinsurance for each Medicare-covered stay.</p>

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Skilled nursing facility (SNF) care* (continued)</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood are covered beginning with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the 	<p>inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.</p> <p>If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>	<p>you haven't been an inpatient at any hospital or SNF for 60 days in a row.</p> <p>If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Skilled nursing facility (SNF) care* (continued)</p> <p>hospital (as long as it provides skilled nursing facility care)</p> <ul style="list-style-type: none"> • A SNF where your spouse or domestic partner is living at the time you leave the hospital 		
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued)</p> <p>Quit Smoking or Vaping Program</p> <p>Learn how to stop smoking, vaping or chewing tobacco from the comfort of your own home.</p> <ul style="list-style-type: none"> Get support and resources online at http://www.myquitforlife.com/aspirus Call the Tobacco and Nicotine Quit Line at 1.855.260.9713 (this call is free). For TTY, call 711(this call is free), 24 hours a day, seven days a week Download the Rally Coach Quit For Life mobile app <p>Over-the-counter nicotine patches, gum or lozenges are also available to eligible Aspirus Health Plan members.</p>	\$0 copayment	\$0 copayment
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication 	\$30 copayment for each Medicare-covered visit.	30% coinsurance for each Medicare-covered visit.

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Supervised Exercise Therapy (SET) (continued)</p> <ul style="list-style-type: none"> • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>		
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently</p>	<p>\$50 copayment per visit.</p> <p>\$130 copayment for each worldwide urgent care visit. ✓</p>	<p>\$50 copayment per visit.</p> <p>\$130 copayment for each worldwide urgent care visit. ✓</p>

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p>Urgently needed services (continued)</p> <p>needed even if you're outside our plan's service area or our plan network is temporarily unavailable.</p> <p><u>Worldwide urgent care:</u></p> <p>Worldwide urgent care applies to urgent care outside the United States and its territories.</p> <p>Coverage includes:</p> <ul style="list-style-type: none">• Urgently needed services that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition <p>Transportation back to the United States or its territories is not covered.</p> <p>If you have urgently needed services outside of the U.S. and its territories, you may have to pay for those services upfront. If this happens, you then have to ask us to pay you back. Your provider may also choose to submit a claim on your behalf. Go to Chapter 5, Section 2 for information on how to get paid back for medical services.</p>		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Vision care Covered services include: <ul style="list-style-type: none"> Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. 1 routine vision (eye) exam and up to 2 refractions every year For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. For people with diabetes, screening for diabetic retinopathy is covered once per year. 	\$40 copayment for each Medicare-covered visit.	30% coinsurance for each Medicare-covered visit.

Covered Service	What you pay In-Network	What you pay Out-of-Network
 Vision care (continued) <ul style="list-style-type: none"> One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. \$175 eyewear allowance every year for prescription eyeglasses and contact lenses, from most eyewear retailers, including: <ul style="list-style-type: none"> - frames and/or lenses - upgrades to existing prescriptions - upgrades to Medicare-covered eyewear after cataract surgery Your prescription eyewear allowance is loaded on your Healthy Benefits+ Visa® card every year. Use your Healthy Benefits+ Visa® card to pay for eyewear purchases up to the allowable amount at the eyewear retailer. The allowance 	\$0 copayment for one pair of standard Medicare-covered eyeglasses or contact lenses. Progressive lenses, no-line bifocal or trifocal lenses, tinting (except for certain ultraviolet-screening coatings), scratch-resistant coatings, or oversized lenses are not covered unless required by Medicare coverage guidelines.	30% coinsurance for one pair of standard Medicare-covered eyeglasses or contact lenses. Progressive lenses, no-line bifocal or trifocal lenses, tinting (except for certain ultraviolet-screening coatings), scratch-resistant coatings, or oversized lenses are not covered unless required by Medicare coverage guidelines.

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> Vision care (continued)</p> <p>expires at the end of the year or upon plan termination.</p> <p>If you did not use your Healthy Benefits+ Visa® card by mistake, or the retailer does not accept your Healthy Benefits+ Visa® card, you may send your itemized eyewear receipt to Aspirus Health Plan at:</p> <p>Attn: Claims Aspirus Health Plan PO Box 51 Minneapolis, MN 55440</p> <p>If the receipt is accepted, a reimbursement check will be sent to the address on record and the amount in your Healthy Benefits+ Visa® card will be removed as redeemed from your Healthy Benefits+ Visa® card. You must be enrolled in an eligible plan at the time of the receipt date and at the time of reimbursement. Aspirus Health Plan is not able to reimburse for any purchases made internationally and reserves the right to deny reimbursement for any reason.</p> <p>To learn more, check your card balance or request a replacement card, visit healthybenefitsplus.com/aspirus or call 1.833.862.8276 (this call is free); TTY 711 (this call is free). This phone number is also on the back of your Healthy Benefits+ Visa® card.</p>		

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

Covered Service	What you pay In-Network	What you pay Out-of-Network
<p> “Welcome to Medicare” preventive visit</p> <p>Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed.</p> <p>Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p> <p>30% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your <i>Welcome to Medicare</i> preventive visit. Please refer to the “Outpatient diagnostic tests and therapeutic services and supplies” section found in this Medical Benefits Chart for other EKGs.</p>

Section 2.1 Extra optional supplemental benefits you can buy

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

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

As a member of the plan, you have the option of purchasing the Choice Dental benefit package. You may select this option (a) upon your initial enrollment into the plan, (b) within the first 30 days of enrollment into the plan, or (c) during the Annual Election Period each year. The monthly premium in 2026 is \$29. This is in addition to your Medicare Parts A and/or B premium, if applicable. The deductible and coinsurance for these covered services do not apply toward your out-of-pocket maximum described in this Chapter 4. Dental services are administered by DentaQuest ("administrator").

Please refer to the 2026 Aspirus Health Plan Medicare Advantage Dental Certificate for a summary of the dental plan benefits, how to access benefits, exclusions and limitations, and other details. If you do not have the 2026 Aspirus Health Plan Medicare Advantage Dental Certificate, you may view it online at medicare.aspirushealthplan.com/member-resources or call Customer Service to request one.

Paying your optional supplemental dental premium.**Option 1: Paying by check**

You can pay your optional supplemental premium by check. We'll send you a monthly billing statement. Mail us a check, made payable to:

Aspirus Health Plan
PO Box 855129
Minneapolis, MN 55485-5129

Premium payments are due on the 1st of each month.

Option 2: Paying online

You can pay your optional supplemental premium by credit card online. Sign up for a secure, online Member Account at medicare.aspirushealthplan.com/member-login. With your Member Account, you can make a one-time credit card payment. We'll still send you a billing statement each month.

Option 3: Paying by phone

You can pay your optional supplemental premium by phone. Call Customer Service and follow the prompts. With this method, you can pay with a credit/debit card or checking/savings account. We'll still send you a billing statement each month.

Option 4: Paying by Electronic Funds Transfer (EFT)

You can have your optional supplemental premium automatically taken out of your checking or savings account. Call Customer Service to get an Automatic Payment form. Fill out the form and send it back to us to set up your monthly payments. You can also find the form online at medicare.aspirushealthplan.com/member-resources.

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

We'll take out your optional supplemental premium payments between the 7th and 10th day of each month. You won't get a monthly billing statement in the mail.

Option 5: Having your optional supplemental premium taken out of your monthly Social Security check

You can have the optional supplemental premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your optional supplemental premium this way. We will be happy to help you set this up.

Option 6: Having your optional supplemental premium taken out of your monthly Railroad Retirement Board check

You can have the optional supplemental premium taken out of your monthly Railroad Retirement Board check. Contact Customer Service for more information on how to pay your optional supplemental premium this way. We will be happy to help you set this up.

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances.

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

Services not covered by Medicare	Covered only under specific conditions
Comprehensive dental care (such as major restorative services)	Comprehensive dental care is covered when you purchase the optional supplemental dental benefit described in Section 2.2 of Chapter 4 of the <i>Evidence of Coverage</i> .
Cosmetic surgery or procedures	<p>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</p> <p>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</p>
<p>Custodial care</p> <p>Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	Not covered under any condition
<p>Experimental medical and surgical procedures, equipment and medications</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community</p>	<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>Go to Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition

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

Services not covered by Medicare	Covered only under specific conditions
Home-delivered meals	For members with congestive heart failure who have been discharged from the hospital. (Go to Help with Certain Chronic Conditions row in the Medical Benefits Chart.)
Homemaker services include basic household help, light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition

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

Services not covered by Medicare	Covered only under specific conditions
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings or dentures	Preventive and diagnostic services are covered as described in the Dental Services section of the Medical Benefits Chart in Chapter 4 of this <i>Evidence of Coverage</i> .
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5

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

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

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

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

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

1. When you got medical care from a provider who's not in our plan's network

When you get care from a provider who is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider

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

who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

4. When you use your worldwide emergency, urgently-needed services or emergency transportation benefits

If you have an emergency, urgent need for services or emergency transportation, outside of the U.S. and its territories, you'll have to pay for those services upfront. You'll then have to ask us to pay you back.

We'll pay you back at rates no greater than the rates at which Original Medicare would pay, had the services been performed in the locality where you live in the U.S. We'll subtract any cost sharing amount you owe from the amount we pay you back. The amount we pay you back may be less than the amount you pay the foreign provider. This is because we'll pay at rates no greater than what Original Medicare would pay, and

because foreign providers might charge more for services than the rates at which Original Medicare would pay.

Save your receipts and send us copies when you ask us to pay you back. Your receipts should show that it's for an emergency or urgently-needed service. We will also need a copy of the medical records for the services you received. Depending on the language, we may not be able to translate the bill into English to process the claim. In some situations, we may need to get more information from you or the provider in order to pay you back for our share of the cost. Go to Chapter 5 for how and where to send us your request for payment.

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months** of the date you got the service or item.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (medicare.aspirushealthplan.com/member-resources) or call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY user call 715.631.7413 or 1.855.931.4852 (this call is free)) and ask for the form.

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

For medical payment requests:

Aspirus Health Plan
Attn: Claims
PO Box 51
Minneapolis, MN 55440

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

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

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

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

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

CHAPTER 6

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about the plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, please call to file a grievance with Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil Rights 1.800.368.1019 or TTY 1.800.537.7697.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't access or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for

Chapter 6. Your rights and responsibilities

research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to the privacy practices of Aspirus Health Ventures, Inc. and its subsidiaries, Aspirus Health Plan, Inc. and Aspirus Health Plan of Michigan, Inc. (collectively, "AHP"). AHP is required by law to maintain the privacy of your Protected Health Information ("PHI"), and to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI.

This notice takes effect May 13, 2024, and we must follow its terms until we replace it. AHP reserves the right to amend this notice at any time and may make the revised notice provisions effective for PHI we already have about you, as well as for any such information we may later receive. We will promptly revise and distribute this notice whenever material changes are made to its terms. You may request a copy of this notice at any time.

Uses and Disclosures of Protected Health Information

The following are examples of permitted uses and disclosures of your PHI by Aspirus Health Plan. This list of examples is not exhaustive.

Treatment. We may disclose your PHI to a health care provider in order to facilitate the medical care you receive from the provider.

Chapter 6. Your rights and responsibilities

Payment. We may use and disclose your PHI to pay for your covered benefits. For example, we may review PHI to pay for your claims from physicians, hospitals, and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, and to obtain premiums.

Health Care Operations. We may use and disclose your PHI in connection with our health care operations, including such activities as:

- Quality assessment and improvement activities;
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a health insurance or health benefits contract. We will not use or disclose genetic information for underwriting purposes;
- Conducting or arranging for medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

In addition, AHP participates in one or more Organized Health Care Arrangements. Members of an Organized Health Care Arrangement may share information with each other for treatment, payment, or health care operation purposes described in this notice.

Business Associates. We may disclose your PHI to AHP's business associates in order for the business associates to provide necessary services to AHP, only if such business associates have agreed in writing to protect the confidentiality of your PHI.

Plan Sponsors. If you are covered under a group health plan, we may disclose your eligibility, enrollment, and disenrollment information to the plan sponsor. We may disclose your PHI to the plan sponsor to permit the plan sponsor to perform certain administrative functions on behalf of the plan, but only if the plan sponsor agrees in writing to use the PHI appropriately and to protect it as required by law.

Persons Involved with Your Care. We may disclose your relevant PHI to family members, friends, or others that you identify as being involved with your health care or with payment for your health care. Before doing so, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based upon our professional judgment of whether the disclosure would be in your best interest.

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Disasters and Medical Emergencies. We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Health-Related Benefits and Services. We may use and disclose your PHI to contact you with information about treatment alternatives, appointment reminders, or other health-related benefits and services that may be of interest to you.

Required Disclosures. We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services if it is necessary for an investigation conducted by the Secretary. We are also required to disclose your PHI to you or to individuals authorized by you, such as your personal representative, upon your request.

Other Uses or Disclosures Permitted or Required by Law. We may use or disclose your PHI as permitted or required by law for the following purposes:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state workers' compensation laws.

Written Authorization. Unless you give us your written authorization, we will not use or disclose your PHI for purposes other than those described in this notice. We will not sell your PHI, or use or disclose your PHI for marketing purposes, or use or disclose your psychotherapy notes, except as permitted by law, unless we have received your written

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authorization. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

Individual Rights

Inspect and Copy. With certain exceptions, you have the right to inspect or copy the PHI that we maintain on you. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we may charge you a reasonable, cost-based fee for staff time to locate and copy your PHI, and postage if you want the copies mailed to you. If we deny your request to access and inspect your information, you may request a review of the denial.

Amendment. You have the right to request that we amend the PHI that we maintain on you. Your request must be in writing and must provide a reason to support the requested amendment. We may deny your request to amend PHI if we did not create it and the originator remains available, if it is accurate and complete, if it is not part of the information that we maintain, or if it is not part of the information that you would be permitted to inspect and copy. If we deny your request, we will provide you with a written explanation of the reason for the denial. You may respond with a statement of disagreement to be appended to the information that you wanted amended.

Confidential Communications. You have the right to request to receive communications of your PHI from us by alternative means or at alternative locations. We must accommodate your request if it is reasonable, if it specifies the alternative means or location, if it clearly states that the disclosure of all or part of the information could endanger you, and if it continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the contract holder of the health plan in which you participate. An explanation of benefits issued to the contract holder for health care that you received, and for which you did not request confidential communications, may contain sufficient information to reveal that you obtained health care, even though you requested that we communicate with you in confidence about the health care..

Request Restrictions. You have the right to request restrictions on how we use or disclose your PHI for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in case of an emergency). Your restriction request must be made to us in writing. A person authorized to make such an agreement on our behalf must sign any agreement to restrictions. We will not agree to restrictions on uses or disclosures that are legally required, or which are necessary in order for us to administer our business.

Disclosure Accounting. You have a right to receive an accounting of the disclosures we have made of your PHI. This accounting will not include disclosures made for treatment, payment,

Chapter 6. Your rights and responsibilities

health care operations, to law enforcement or corrections personnel, pursuant to your authorization, directly to you, or for certain other activities. Your request for an accounting must be made to us in writing and must state the time period, for which you would like to receive the accounting which may not exceed six years. We may charge you a reasonable, cost-based fee for responding to additional request if request this accounting more than once in a 12-month period.

Breach Notification. You have the right to be notified by us if there is a breach of your unsecured PHI.

Copy of Notice. You are entitled to receive this notice in written form, even if you have received it on our website or by electronic mail (email). Please contact us using the information listed at the end of this notice to obtain a written copy of the notice.

Protection of PHI. AHP is committed to ensuring that your PHI is protected from unauthorized use or disclosure. We have implemented strong security measures and processes to keep oral, written, and electronic PHI secure across our organization. For example, an employee or contractor who accesses your PHI must comply with all of our information security requirements including, but not limited to, signing confidentiality agreements, completing annual information security training, and using encryption when transmitting data to an external party.

Questions and Complaints

If you believe that AHP may have violated your privacy rights, or if you disagree with a decision we made regarding one of the individual rights provided to you under this notice, you may submit a complaint to us using the contact information provided at the end of this notice. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you in any way if you choose to file a complaint regarding our privacy practices with us or with the U.S. Department of Health and Human Services.

Nonpublic Personal Information Privacy Practices

Aspirus Health Ventures, Inc. and its subsidiaries, Aspirus Health Plan, Inc. and Aspirus Health Plan of Michigan, Inc. (collectively, “AHP”), are committed to protecting the confidential information of our customers. We at AHP value our relationship with you and take the protection of your personal information very seriously. This notice describes our privacy policy and explains the types of information we collect, how we collect it, and to whom we may disclose it.

Information We May Collect. AHP may collect and use nonpublic personal information about you from the following sources:

Chapter 6. Your rights and responsibilities

- Information we receive from you on applications and other forms that are provided to us, such as your name, address, Social Security number, date of birth, marital status, dependent information, employment information, and medical history;
- Information about your transactions with us, our affiliates, and others, such as health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information; and
- Information we receive from consumer reporting agencies, employers, and insurance companies, such as credit history, creditworthiness, and information verifying employment history or insurance coverage.

Information We May Disclose. AHP does not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We share nonpublic personal information only to the extent necessary for us to take care of our customers' claims and other transactions involving our products and services.

When necessary, we share a customer's nonpublic personal information with our affiliates and disclose it to health care providers, other insurers, third- party administrators, payors, vendors, consultants, government authorities, and their respective agents. These parties are required to keep nonpublic personal information confidential as required by law.

AHP does not share nonpublic personal information with other companies for their own marketing purposes. AHP may disclose such information to companies, that perform marketing services on our behalf, or to other companies with whom we had joint marketing agreements. These companies must keep your nonpublic personal information confidential, as required by law.

Confidentiality and Security. At AHP, we restrict access to nonpublic personal information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards to protect nonpublic personal information against unauthorized access and use. These safeguards comply with federal regulations on the protection of nonpublic personal information.

AHP will amend this notice as necessary and appropriate to protect nonpublic personal information about our customers.

Further Information. For additional information regarding this notice or our privacy practices in general, please call the AHP Privacy Officer at 715.843.1393, Monday through Friday, 8 am to 5 pm, or write to us at:

Privacy Officer

Aspirus Health Plan

3000 Westhill Drive, Suite 303

Wausau, WI 54401

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

As a member of Aspirus Health Plan Elite, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)):

- **Information about our plan.** This includes, for example, information about our organization, its services, its practitioners and providers, and member rights and responsibilities. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, refer to the *Provider and Pharmacy Directory*.
 - For more detailed information about our providers, you can call Customer Service or visit our website at search.aspirushealthplan.com.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.
 - 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 document. 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.)

Chapter 6. Your rights and responsibilities

- **Information about how Aspirus Health Plan evaluates new technology for inclusion as a covered benefit.**
 - When new technologies enter the marketplace (devices, procedures or drugs), Aspirus Health Plan's medical leaders carefully evaluate them for effectiveness. We use information gathered from many sources and standard-setting organizations in our evaluation.
 - Aspirus Health Plan's clinical and quality committees and medical directors carefully research and review new technologies before determining their medical necessity and/or appropriateness.
 - Aspirus Health Plan uses information from many sources in our evaluation efforts, including the Hayes, Inc. Technology Assessment Reports, published peer-reviewed medical literature, consensus statements and guidelines from national medical associations and physician specialty societies, the U.S. Food and Drug Administration (FDA), other regulatory bodies, and internal and external expert sources.

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

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

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

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

Chapter 6. Your rights and responsibilities

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

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

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

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Wisconsin Department of Safety and Professional Services at 608.266.2112 or 1.877.617.1565. TTY users call 711.

Chapter 6. Your rights and responsibilities

If you believe that a health plan did not follow the advance directive requirements, you may file a complaint with the Wisconsin Office of the Commissioner of Insurance at 1.800.236.8517. TTY users call 711.

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

You have the right to voice complaints or submit appeals about the organization for the care it provides.

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

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

You have the right to be treated with respect and dignity. If you feel that you are being treated unfairly or your rights are not being respected, there are actions you can take.

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 (TTY users call 1.800.537.7697) or call your local Office for Civil Rights.

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

- Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).
- Call your local SHIP. For contact information, go to Chapter 2, Section 3.
- Call Medicare at 1.800.MEDICARE (1.800.633.4227) (TTY users call 1.877.486.2048).

Section 1.8 How to get more information about your rights and responsibilities

Get more information about your rights and responsibilities from these places:

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- **Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).**
- **Call your local SHIP.** For contact information, go to Chapter 2, Section 3.
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections*. (available at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Call 1.800.MEDICARE (1.800.633.4227) (TTY users call 1.877.486.2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show 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 get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Learn as much as you can about your health problems so you can participate in developing mutually agreed upon treatment goals with your provider.
 - Make sure your doctors know all of the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.

Chapter 6. Your rights and responsibilities

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

SECTION 3 If you want more information or have suggestions on information in this chapter

Section 3.1	If you have questions or concerns about information in this chapter
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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.

Section 3.2	You have the right to make recommendations regarding our member rights and responsibilities policy
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Call Customer Service to provide that information to us. We welcome your feedback. Phone numbers and calling hours are printed on the back cover of this booklet.

CHAPTER 7

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

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) for help. In some situations, you may also want help or guidance from someone who is not connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare for help.

- Call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048.
- Visit www.medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Go to **Section 9** 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 coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

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

Making an appeal

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

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

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

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

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

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

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

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

- **Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free))**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.aspirushealthplan.com/member-resources.
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.aspirushealthplan.com/member-resources. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

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

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

If you're not sure which information applies to you, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). You can also get help or information from your SHIP.

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

Section 5.1	What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care
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Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

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

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

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

Section 5.2 How to ask for a coverage decision

Legal Terms

A coverage decision that involves your medical care is called an organization determination .
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A fast coverage decision is called an expedited determination .
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Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

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

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

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

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

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

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

- However, if you ask for more time, or if we need more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service.

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

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

- If you believe we shouldn't take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms

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

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

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

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

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

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

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

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

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on

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

to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
 - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage **within 30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) or 1.800.MEDICARE (1.800.633.4227) (TTY users call 1.877.486.2048).

1. **Read this notice carefully and ask questions if you don't understand it. It tells you about:**
 - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay.
 - Where to report any concerns you have about the quality of your hospital care.
 - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so that we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
 - If you sign the notice more than 2 calendar days before the day you leave the hospital, you'll get another copy before you're scheduled to be discharged.
 - To look at a copy of this notice in advance, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) or 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week (TTY users call 1.877.486.2048). You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

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

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

How can you contact this organization?

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

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) or 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048. Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the independent review organization says yes:

- We must reimburse you for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it 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.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

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

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

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

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

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

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

Legal Term

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help. Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)). Or call your State Health Insurance Assistance Program. SHIP contact information is available in Chapter 2, Section 3.

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

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

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

How can you contact this organization?

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

Act quickly:

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

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.

- By the end of the day the reviewers tell us of your appeal, you'll get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

- If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the 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 the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

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

Making complaints

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

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

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

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

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, or other health professionals? Or by our Customer Service or other staff at our plan? <ul style="list-style-type: none"> – Examples include waiting too long on the phone, or in the waiting or exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a "fast coverage decision" or a "fast appeal," and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for giving you a coverage decision or appeals; you can make a complaint. • You believe we aren't meeting the deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

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

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

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

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

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

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

- **Calling Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free), 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) is the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Our complaint procedure includes both oral and written complaint processes as described below.

Oral complaint

- If we are not able to resolve your oral complaint right away over the phone, we will look into your complaint and give you a response as quickly as your situation requires based on your health status, but no later than 30 calendar days from the date you called us.
- We will call and tell you what we can do about your complaint or tell you our decision. If you request a written response to your oral complaint, we will respond in writing to you.
- We may extend the timeframe for resolving your oral complaint by an additional 14 calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you in writing of the reason(s) for the delay.

- If we cannot resolve your oral complaint over the phone, or if you do not agree or are dissatisfied with our response, we have a formal procedure where you can file a written grievance.

Written grievance

- You can **write** us about your complaint. Mail your written complaint letter to:
Attn: Member Appeals and Grievances
Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440-9972
- Or **email** us at cagMA@aspirushealthplan.com.
- You can also **fax** your written complaint to us at 715.631.7439 or 1.855.931.4857.
- We can help you put your complaint in writing. If you need help, call Customer Service.
- We will notify you within ten (10) calendar days that we have received your written complaint.
- Within 30 days we will send you a letter about our findings or decision.
- We may extend the time frame for resolving your written complaint by an additional 14 calendar days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we extend the deadline, we must immediately notify you in writing of the reason(s) for the delay.

If your grievance is about our denial of an expedited reconsideration, organization determination, or coverage determination, we'll give you a decision within 24 hours.

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

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

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

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

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you an **answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

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

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

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

Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Aspirus Health Plan Elite directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1.800.MEDICARE (1.800.633.4227). TTY/TDD users call 1.877.486.2048.

CHAPTER 8

*Ending membership in
our plan*

SECTION 1 Ending your membership in our plan

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

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

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

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

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

You can end your membership during the **Open Enrollment Period** each year. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

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

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

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

Chapter 8. Ending membership in our plan

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

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

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

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

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

Chapter 8. Ending membership in our plan

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

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

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

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

- Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).
- Find the information in the *Medicare & You 2026* handbook.
- Call Medicare at 1.800.MEDICARE (1.800.633.4227) (TTY users call 1.877.486.2048).

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	<ul style="list-style-type: none">• Enroll in the new Medicare health plan.• You'll automatically be disenrolled from Aspirus Health Plan Elite when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan.	<ul style="list-style-type: none">• Enroll in the new Medicare drug plan.• You'll automatically be disenrolled from Aspirus Health Plan Elite when your new drug plan's coverage starts.

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Original Medicare *without* a separate Medicare drug plan.

- **Send us a written request to disenroll** or visit our website to disenroll online. Call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free) if you need more information on how to do this.
- You can also call **Medicare** at 1.800.MEDICARE (1.800.633.4227) and ask to be disenrolled. TTY users call 1.877.486.2048.
- You'll be disenrolled from Aspirus Health Plan Elite when your coverage in Original Medicare starts.

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

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

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

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

SECTION 5 Aspirus Health Plan Elite must end our plan membership in certain situations

Aspirus Health Plan Elite must end your membership in our plan if any of the following happen:

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- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
 - If you move or take a long trip, call Customer Service 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Customer Service at 715.631.7411 or 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week (TTY users call 715.631.7413 or 1.855.931.4852 (this call is free)).

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

Aspirus Health Plan Elite isn't allowed to ask you to leave our plan for any health-related reasons.

What should you do if this happens?

If you feel that you're being asked to leave our plan because of a health-related reason, call Medicare at 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048.

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

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

CHAPTER 9

Legal Notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 (TTY 1.800.537.7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index.html>.

If you have a disability and need help with access to care, call Customer Service. 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, Aspirus Health Plan Elite, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Notice about member's term of coverage

Your coverage under this *Evidence of Coverage* will begin on the CMS-confirmed effective date and will end on the date of disenrollment, or on December 31. Services must be received (expenses must be incurred) during the term of your coverage. In no event is there coverage under the plan before your effective date or after your disenrollment date with one exception. If on December 31 you are an inpatient in a hospital, a rehabilitation hospital, or a distinct part of a hospital used as an inpatient rehabilitation unit, your coverage for Medicare Part A inpatient expenses will continue until you are discharged from that place of confinement.

SECTION 5 Notice about amendments

From time to time, this *Evidence of Coverage* may be amended. If that happens, either a whole new *Evidence of Coverage* or relevant amendment pages will be sent to you. Any change or any rider added to this *Evidence of Coverage* is effective on its own specific effective date.

No change will be made to this *Evidence of Coverage* unless made by an amendment or a rider that has received prior approval from CMS. No one has the authority to make any oral changes or amendments to this *Evidence of Coverage*.

SECTION 6 Notice about assignment of rights

No rights under this *Evidence of Coverage* are assignable by you or your representative. Any attempted assignment will be void. However, you may assign payment for covered services to your physician or other provider.

SECTION 7 Notice about conformity with statutes

Any provision of this *Evidence of Coverage* that is in conflict with the requirements of Federal statutes and regulations, or the applicable statutes and regulations of the jurisdiction in which it is delivered, to the extent not preempted by Federal law, is hereby amended to conform to the requirements of such statutes and regulations. If during the term of this *Evidence of Coverage* any Federal or state laws or regulations are amended, this *Evidence of Coverage* is hereby amended to conform to the minimum requirements of such changes, as of their legislative effective dates.

SECTION 8 Notice about clerical error

A clerical error will neither deprive you of coverage nor create a right to benefits not covered under this *Evidence of Coverage*.

SECTION 9 Appointed representatives

You can name (appoint) someone to serve as your personal representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you currently have a Power of Attorney, you will need to send a copy of the papers to us so that this information will be saved in your file. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at the address shown in Chapter 2. You can call the Customer Service number in Chapter 2 to learn how to name your representative and to receive the Statement of Representative form. Please note that we cannot discuss member-specific information with someone other than the member or member's representative unless otherwise allowed by law.

SECTION 10 Provider opt-out of Medicare

A physician or other provider can choose to opt-out of the Medicare program by providing most services that would otherwise be covered by Medicare to any Medicare beneficiary through a private contract. Services provided by such physicians and providers will not be covered under this plan nor under Original Medicare. Emergency care, urgently needed care, and services provided as a supplemental benefit by a physician or practitioner are exceptions to this rule. You are responsible for asking out-of-network physicians or providers if they have opted out of the Medicare program.

SECTION 11 Third party liability

If you suffer an injury or illness for which a third party is liable or responsible due to a negligent or intentional act or omission causing such illness or injury to you, you must promptly notify us of the illness or injury. A "third party" is any person other than you or Aspirus Health Plan, and includes any insurer providing coverage available to you, including but not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation and all other first party types of coverage. We will send you a statement of the amounts we paid for services provided in connection with the injury or illness. If you recover any sums from any third party in connection with the illness or injury, we shall be reimbursed out of such recovery for the payments we made on your behalf, subject to the limitations in the following paragraphs:

Chapter 9. Legal Notices

1. **Our payments are less than the judgment or settlement amount.** If our payments are less than the total recovery amount from any third party (the "third party recovery amount"), then our reimbursement will be calculated as follows:

Step One: Determine the ratio of the procurement costs to the third party recovery amount. "Procurement costs" means attorney's fees and other costs and expenses incurred in obtaining a settlement or judgment in connection with the third party recovery amount.

Step Two: Apply the ratio calculated in Step One to our payments. The result is our share of the procurement costs.

Step Three: Subtract our share of the procurement costs from our payments. The remainder is our reimbursement amount.

2. **Our payments equal or exceed the judgment or settlement amount.** If our payments equal or exceed the third party recovery amount, our reimbursement amount is the total third party recovery amount minus the total procurement costs.
3. **We incur procurement costs because of opposition to its recovery.** If we must bring suit against the party that received the third party recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
 - a. Our payments made on your behalf for services; or
 - b. The third party recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts so recovered through settlement, judgment or verdict. You may be required by us to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

CHAPTER 10

Definitions

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

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

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

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. A new benefit period can begin only after any existing benefit period ends and there is no limit to the number of benefit periods. For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in skilled nursing facilities. For inpatient hospital care, the cost sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital.

Calendar Year – A twelve (12) month period that begins January 1 and ends twelve (12) consecutive months later on December 31.

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

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers.

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

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

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

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

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

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

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

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

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman,

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loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

E-visit – Secure, encrypted web access via remote technology, providing online exchange of non-urgent medical information between a health care provider and an established patient. E-visits follow established medical protocols and the prescribing and/or treatment recommendations follow state laws and are within the provider's scope of practice.

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

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

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

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

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

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit,

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you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Lifetime Reserve Days – In Original Medicare, these are additional days that Medicare will pay for when you’re in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

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

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

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

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

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

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

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

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

Medicare Fee Schedule – A listing of fees used by Original Medicare to pay providers or other suppliers.

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

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

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

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

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

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

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

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

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by

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

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

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services 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 services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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

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

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Prior Authorization – Approval in advance to get covered services **based on specific criteria**. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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

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

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

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

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

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

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

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

Telehealth Services – Interactive, real-time virtual visits that allow providers to evaluate, diagnose and treat you without an in-person office visit. They are often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services.

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

Virtuwell® – A 24/7 online service that may be used to receive a diagnosis and treatment for simple, common conditions. These conditions include: colds, coughs, allergies, ear pain, sinus infections, pink eye, minor skin conditions, and yeast and urinary tract infections.

Access Virtuwell® at www.virtuwell.com.

Aspirus Health Plan Elite Customer Service

Customer Service - Contact Information

Call	715.631.7411 1.855.931.4850 (this call is free) 8 am – 8 pm, seven days a week Customer Service also has free language interpreter services available for non-English speakers.
TTY	715.631.7413 1.855.931.4852 (this call is free) 8 am – 8 pm, seven days a week These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
Fax	715.787.7322
Write	Attn: Customer Service Aspirus Health Plan PO Box 51 Minneapolis, MN 55440-9972
Website	medicare.aspirushealthplan.com

State of Wisconsin - Board on Aging & Long Term Care

State of Wisconsin - Board on Aging & Long Term Care is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Contact Information

Call	1.800.242.1060 (this call is free)
TTY	Call the Wisconsin Relay Service at 711 or use your preferred relay service. (This call is free.)
Write	State of Wisconsin - Board on Aging & Long Term Care 1402 Pankratz Street, Suite 111 Madison, Wisconsin 53704-4001
Website	longtermcare.wi.gov

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