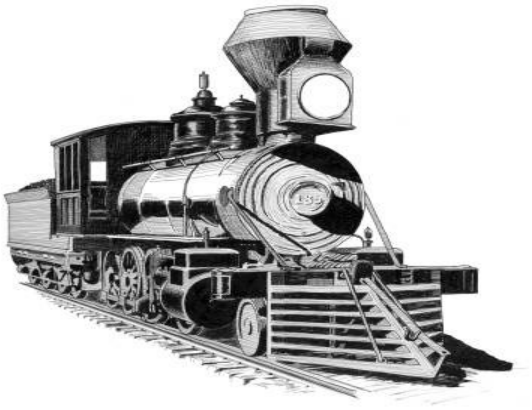

EVIDENCE OF COVERAGE

SFEHACL HCPP PART B MEDICARE HEALTH COST PLAN & MEDICARE PART A & B SECONDARY PLAN

EVIDENCE OF COVERAGE (EOC) 2024

Your Medicare Part A, B & SFEHACL Health Benefits and Services as a Member of SFEHACL
January 1, 2024, through December 31, 2024

- This document gives the details about your SFEHACL Medicare health coverage and explains how to get the care you need. This is an important legal document. Please keep it in a safe place.
- This plan is offered by Santa Fe Employes Hospital Association-Coast Lines. When this document says we, us, our, plan, or our plan, it means the Medicare plans of Santa Fe Employes Hospital Association-Coast Lines, or SFEHACL. The plans can include the SFEHACL Prime Medicare Part D Prescription Drug Plan (PDP), administered by OptumRx, HCPP Part B and Part A & B Secondary plan.
- Your benefits, provider network, premium, deductible, and/or copayments/coinsurance may change on January 1st of each year. You will receive an Annual Notice of Change (ANOC) in October of the previous year outlining these changes.
- For questions or more information, please visit our website at santafeha.com, or call SFEHACL Member Services, Monday through Friday from 7:30 AM to 4:00 PM Pacific Time at 1-877-968-3550. Calls to this number are free. TTY call 711.

SFEHACL Member Services
877-968-3550
TTY/TDD Call 711
Website: santafeha.com

Table of Contents

Section 1 Important phone numbers and resources

How to contact SFEHACL Member Services

If you have any questions or concerns, please call or write to SFEHACL Member Services. We will be happy to help you. Our business hours are 7:30 AM to 4:00 PM, Pacific Time, Monday through Friday.
CALL: 1-877-968-3550 Calls to this number are free. TTY/TDD calls use the national access number, 711.
FAX: 1-(626) 967-3161
WEBSITE: santafeha.com
WRITE: SFEHACL - 551 East San Bernardino Road, Covina, CA 91723

How to contact us to make a complaint, ask for a coverage decision or request an appeal

Please contact the above SFEHACL numbers for questions. For more information about coverage decisions and appeals please refer to Section 10, "*Decisions and appeals*." For more information about complaints, please refer to Section 9, "*How to file a complaint*."

Medicare Program help line 1-800-633-4227 (TTY 1-877-486-2048)

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify SFEHACL if you are not eligible to remain a member on this basis. SFEHACL must disenroll you if you do not meet this requirement. CMS contracts with and regulates Medicare managed care organizations (including the SFEHACL HCPP) and Medicare private fee-for-service organizations.

Here are ways to get help and information about Medicare from CMS

Call Medicare at 1-800-633-4227 to ask questions or to request free information documents from Medicare. You can call the national Medicare help line 24 hours a day, 7 days a week. The TTY number is 1-877-486-2048 (special telephone equipment required). Calls to these numbers are free.

Use a computer to look at medicare.gov the official government website for Medicare information. This website gives you a lot of up-to-date information about Medicare, as well as information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes documents you can print directly from your computer. It has a tool to help you compare Medicare managed care plans in your area. You can also search the Helpful Contacts Section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this website using their computers.

In addition, the Medicare program has written a document called Your Medicare Rights and Protection. To get a free copy, call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048). Or you can visit the Medicare website at www.medicare.gov to order this document or print it directly from your computer. You can call 24 hours a day, 7 days a week.

Railroad Retirement Board (RRB)

Most SFEHACL Medicare members receive their Medicare benefits through the Railroad Retirement Board under Railroad Medicare. You can call your local Railroad Retirement Board office or 1-877-772-5772 (calls to this number are free). The TTY number is 312-751-4701 (special telephone equipment required). You can also visit their Website at rrb.gov.

Palmetto Government Benefits Administrator (Railroad Medicare)

Palmetto GBA may process your Medicare Part B claims that are not sent to SFEHACL HCPP. Palmetto GBA is the Railroad Medicare Part B carrier. Palmetto GBA would process all of your Medicare claims from providers not in-network in the SFEHACL network. Whether or not the provider is in-network with SFEHACL, Palmetto GBA is still able to process your claims. You can call Palmetto GBA at 1-800-833-4455 (calls to this number are free) or write to Palmetto GBA, PO Box 10066, Augusta, GA 30999-0001.

State Health Insurance Assistance Program (SHIP)

State Health Insurance Assistance Program (SHIP) is an organization in your state that provides free Medicare help and information. SHIPs are state organizations paid by the Federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare managed care plan for the first time. You can find the SHIP in your state by calling the national 1-800-MEDICARE (1-800-633-4227) telephone number. You can also find the Website for your local SHIP at medicare.gov/ or ship.help.org.

Quality Improvement Organization (QIO)

Quality Improvement Organization (QIO) is a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare. A QIO is paid by the Federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. Medicare complaints they review include those about quality of care, and patients who think the coverage for their hospital stay, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility services are ending too soon. See Section 9 for more information about complaints. You can find the QIO in your state by calling the national 1-800-MEDICARE (1-800-633-4227) telephone number.

Medicaid Agency

A Medicaid Agency is a state government agency that handles health care programs for individuals with low income. Medicaid is a joint Federal and state program that helps with medical costs for some people with low income and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare

premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your state Medicaid Agency.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. The TTY number is 1-800-325-0778 (you need special telephone equipment to use this number). Calls to these numbers are free. You can also visit their Website at ssa.gov.

See Section 1- page1 for information regarding the Railroad Retirement Board.

OptumRx

The SFEHACL Medicare Part D prescription drug plan is administered by OptumRx.
When you are enrolled in our plan, you may continue to use Depot Drug Mail Order for your prescriptions, as long as Depot Drug ships to the state in which you live. If Depot Drug does not ship to your state, you may use the OptumRx mail order pharmacy.

Please note: Depot Drug mail is the preferred mail-order pharmacy. Depot Drug mail does not dispense medications in certain states (listed below).

Depot Drug is NOT AVAILABLE in the following states: Alabama, Alaska, American Samoa, Connecticut, Delaware, District of Columbia, Guam, Hawaii, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Northern Mariana Islands, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, US Virgin Islands, Vermont, Virginia and West Virginia.

OptumRx is the preferred mail-order pharmacy for the above states.

You may contact OptumRx Member Services at 1-866-443-1095.

Section 2 Getting care you need and rules you must follow

What is the SFEHACL Health Care Prepayment Plan (HCPP)?

SFEHACL is contracted as a Health Care Prepayment Plan (HCPP) with the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers Medicare. This contract authorizes SFEHACL to pay your Original Medicare Part B claims to in-network providers for office visits, services, consultations, hospital visits, and surgical procedures. When SFEHACL HCPP receives an in-network physician's claim for your services, payments for Original Medicare Part B benefits and your SFEHACL Medicare Secondary Plan benefits are made in one check directly to the physician, which eliminates billing Railroad Medicare and you.

The SFEHACL HCPP contract with CMS renews annually on January 1 of each year. Either CMS or SFEHACL may terminate the contract by providing advance notice. If the contract ends, your SFEHACL Medicare Secondary Plan benefits will continue in force, and we will explain what your options are at that time if it should ever occur. This SFEHACL Health Evidence of Coverage (Evidence of Coverage) is part of our contract with you about how SFEHACL covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage. These notices are sometimes called riders or amendments.

SFEHACL Medicare members continue to get their Medicare benefits through Original Medicare Part A and B whether or not the provider is in-network with SFEHACL. SFEHACL HCPP does not change Original Medicare Part A or B benefits; congressional law creates and defines those benefits. The SFEHACL Board of Trustees determines only the premium amounts and the benefits that are paid secondary to Original Medicare under the SFEHACL Medicare Secondary Plan (MSP).

You may choose to get care out-of-network anywhere and at any time using your Original Medicare benefits. SFEHACL HCPP cannot pay the Original Medicare Part B payments for SFEHACL out-of-network providers even if it is an emergency or urgent care. Railroad Medicare processes the Medicare claims for your out-of-network providers and certain in-network Part B benefits. Your SFEHACL Medicare Secondary Plan benefit payment will cover 100% after Medicare on Medicare approved charges.

Participating physicians can send claims to SFEHACL HCPP or Railroad Medicare to receive the Original Medicare Part B payment. If their claims are sent to Railroad Medicare, SFEHACL will receive Medicare payment information directly from Medicare through an electronic interface and will automatically PAY YOUR Medicare Secondary Plan benefits.

SFEHACL HCPP does make the Original Medicare Part B payment for the following SFEHACL in-network physician services:

- Office visits
- Consultations
- Hospital physician visits
- Surgical procedures

SFEHACL HCPP does not make the Original Medicare Part B payment for any of the items and/or services listed below.

Regardless of whether the provider is in- or out-of-network, claims for the following services should be sent to Railroad Medicare. SFEHACL will get the information electronically from Medicare to process your claim.

- Acupuncture
- Alcohol and substance abuse treatments
- Ambulance services
- Ambulatory Surgical Facility (ASF) and other facility services
- Anesthesia services
- Chiropractic services
- Clinical research
- Dialysis treatment and supplies
- DME, orthotics and prosthetics
- Hospice services
- Home nursing services
- In and outpatient hospital services and other facility services
- Mammography
- Independent clinical laboratory and pathology
- Independent radiology
- IV home infusion therapy
- Nutritional education and/or counseling
- Nutritional supplements
- Optometry
- Oral cancer, immunotherapy, chemotherapy, and intravenous immune globulin drugs
- Organ transplant services
- Oxygen and associated equipment and supplies
- Physical, speech and occupational therapy
- Podiatry services
- Preventive or screening services
- Telehealth

The SFEHACL Medicare Part A and B Secondary Plan

Time limit for filing a claim for SFEHACL MSP benefits

Claims for Medicare secondary benefits under the SFEHACL MSP must be filed with SFEHACL within one-year of the time the claim was first processed by any Medicare.

SFEHACL Medicare Secondary Plan (MSP) makes payments for covered benefits after Original Medicare Part A or B or the SFEHACL HCPP has paid the primary Medicare Part B payment for allowed services. SFEHACL MSP pays the Medicare Part A and B annual deductible amounts and coinsurance for allowed charges for covered benefits. You may be partly or totally financially responsible for charges that Medicare did not pay from out-of-network providers. A SFEHACL out-of-network provider is a physician, hospital, or other health care provider who

has not signed a SFEHACL participation agreement. SFEHACL does not know if these providers participate with Medicare or not. All Medicare members who elect coverage under the SFEHACL MSP are also automatically enrolled in the SFEHACL Medicare HCPP. Members must be entitled to Original Medicare Part A and enrolled in Part B to elect coverage under the SFEHACL MSP and HCPP.

There are some benefits that are not covered by Original Medicare Part A and B that are covered by your SFEHACL MSP (see SFEHACL Medicare Plan Benefits Chart in Section 4).

If Medicare does not allow for payment for an item or service, SFEHACL MSP will not make a payment. (see SFEHACL Medicare Plan Benefits Chart in Section 4). Your SFEHACL MSP does not make payment for any service or item that is already paid in full by Medicare, or an amount higher than the Medicare allowed amount for any covered benefit. Benefit payments are secondary to Original Medicare Part A and B payments with very few exceptions.

Use your SFEHACL Health Insurance Card and your red, white, and blue Medicare Card

You must present both your red, white and blue Medicare Card and your SFEHACL Health Insurance when you receive hospital, physician, and other health care services. Your SFEHACL Health Insurance ID Card has a unique ID number for you, which is not your Social Security number, or your Medicare number. Your unique ID number identifies you as a SFEHACL Medicare HCPP & MSP plan member. Your SFEHACL Health Insurance ID Card instructs in-network physicians to send your Medicare claims to SFEHACL HCPP.

Your SFEHACL Health Insurance does not guarantee coverage of all services or current eligibility. You or a provider can verify your eligibility and benefits by calling SFEHACL Member Services. Your insurance card lists the SFEHACL telephone number and the electronic payer ID number. If you lose your SFEHACL insurance card, you can obtain a replacement by calling SFEHACL Member Services at 1-877-968-3550. TTY call 711. If you lose your Medicare card, you will need to contact the RRB for a replacement. You can contact the RRB at 1-877-772-5772 (calls to this number are free). Their TTY number is 312-751-4701. You can visit their website at rrb.gov/

Help us keep your membership record up to date

By law, the contact information SFEHACL has on file for you must match the contact information on file with the RRB. This includes your name, address, phone number and email.

Please help us keep your membership record up to date by letting the RRB know right away if there are any changes in your name, address, phone number or email. You can contact the RRB at 1-877-772-5772 (calls to this number are free). Their TTY number is 312-751-4701. You can visit their website at www.rrb.gov.

Once you have notified the RRB of any changes, please advise SFEHACL Member Services about those changes as well. If you have any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers'

compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident, please contact SFEHACL Member Services.

PLEASE NOTE: Medicare requires that you have a physical address, not a P.O. Box.

Medicare law requires us to keep this information current. Call SFEHACL Member Services at 1-877-968-3550. TTY call 711.

SFEHACL requires electronic claims submission

SFEHACL requires electronic claims submission from our Medicare Part B in-network physicians for administrative simplification in support of the Health Insurance Portability and Accountability Act (HIPAA). CMS guidelines require physicians to submit claims electronically.

Please let your physician know that electronic claim submission to SFEHACL is easy to establish. SFEHACL has electronic claim submissions routed through Change Healthcare. They review and validate the claims for HIPAA compliance and forward them directly to us for consideration. Providers can submit claims electronically to Change Healthcare, or they may contact Change Healthcare at 1-866-742-4355 or go to www.changehealthcare.com. The SFEHACL Electronic Payer ID number is 87042. In-network providers who have a CMS Administrative Simplification Waiver allowing paper billing can include a copy of their waiver with each paper claim.

SFEHACL in-network providers

Providers: Doctors and other health care professionals licensed by the state to provide medical services and care. The term provider also includes hospitals and other health care facilities.

In-network Providers: Doctors and other health care professionals, medical groups, hospitals and other health care facilities that have an agreement with us to accept Medicare payment and your MSP payment as payment in full.

Covered Services or Covered Benefits: General terms we use for all the medical care, health care services and equipment covered by Original Medicare Part A and B and/or the SFEHACL MSP.

The SFEHACL Medicare Secondary Plan: Pays Medicare covered benefits at 100 percent of the allowed amount that Medicare did not pay (known as the coinsurance), Your MSP also pays the Medicare annual deductible amount for covered benefits If Medicare denies services than SFEHACL MSP will not make a payment and you may be responsible for the charges.

An SFEHACL in-network provider is a physician, hospital, other facility, or other health care provider who has signed an agreement with SFEHACL. SFEHACL in-network providers do not discount Medicare services. They agree to participate with the SFEHACL HCPP and accept the Medicare allowed amount as payment in full for their services. Very rarely a SFEHACL in-network physician will not participate with Medicare. In this case, SFEHACL will make MSP

payment up to the limiting charge or Medicare allowed amount for the covered services. Remember that not all SFEHACL in-network providers are able to take new patients.

Out-of-network providers

You may be financially responsible for charges that Medicare did not pay from out-of-network providers. A SFEHACL out-of-network provider is a physician, hospital, or other health care provider who has not signed a SFEHACL agreement. SFEHACL does not know if these providers participate with Medicare or not. Your Original Medicare continues to cover services from providers who do not participate with SFEHACL but participate with Medicare.

The SFEHACL HCPP is a national plan

The SFEHACL HCPP is a national plan. SFEHACL has over 929,000 in-network providers across America including Alaska and Hawaii. Most states have a complete SFEHACL in-network provider network. You can obtain services from any SFEHACL in-network provider in any state and still receive maximum benefit payment. If you go out of the SFEHACL network to an out-of-network provider, you will receive your Original Medicare benefits. As a SFEHACL Medicare member, you will continue receiving benefits from Original Medicare. You are also eligible to obtain services according to your Original Medicare American boundaries and foreign travel restrictions.

To get a list of SFEHACL in-network providers

You can obtain a list of or verify current SFEHACL in-network providers for any area you need on the SFEHACL Website at santafeha.com (click on Find a Doctor/Facility), or by calling Member Services at 1-877-968-3550. TTY call 711. If you have any questions or need to verify the participation status of a provider, Member Services can give you the most up-to-date information.

Find SFEHACL in-network providers when you travel

Locate SFEHACL in-network providers and hospitals in the travel area before you leave. You can print a current in-network provider directory for any area from our Website at santafeha.com (click on Find a Doctor/Facility) or call SFEHACL Member Services at 1-877-968-3550, (TTY/TDD call 711) and we will print a directory and mail it to you. If you are traveling by car, consider finding in-network providers in all areas that you will travel through, as well as at your destination.

Access to your personal information

You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care.

Primary Care Provider (PCP)

Your SFEHACL plan does not require that you use a PCP, but we do recommend that you establish one to help you with your healthcare decisions. Besides providing much of your care, a PCP will help arrange or coordinate your x-rays, laboratory tests, therapies, care from doctors

who are specialists, hospital admissions, and follow-up care. Primary care provider specialties are usually family practice, general practice, gynecology, geriatric medicine, or internal medicine.

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You do not have to contact a SFEHACL in-network physician or get permission from anyone in an emergency. You can call 911 for immediate help by phone or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

SFEHACL does not require referral for getting care from specialists

SFEHACL does not require you to have any type of referral to see a specialist. You should make certain the specialist you need to see is SFEHACL in-network so that you are not responsible for out-of-pocket expenses. Even if a SFEHACL in-network doctor sends you to a SFEHACL out-of-network specialist, you could be responsible for out-of-pocket expenses.

A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions).

What if your doctor stops in-network with SFEHACL?

Sometimes a doctor, specialist, clinic, or other SFEHACL in-network provider you are using discontinues participation with SFEHACL. If this happens, you can switch to another provider who is in-network to receive maximum SFEHACL MSP benefits. Original Medicare benefits still cover services from providers who are not in-network with SFEHACL.

Can your benefits change during the year?

The Medicare program has rules about when we can make changes to your benefits. We can increase your benefits at any time during the calendar year. Here are some examples:

- If SFEHACL adds a new benefit or enhances existing benefit to your plan during the year, you will be eligible for those benefits. You may have an out-of-pocket expense related to these added benefits.
- If we decide to reduce the amount of a copayment, or plan premium, this change would also be an increase in your benefits because you would be getting the same benefits for less money.

The Medicare program does not allow us to decrease your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any decreases we make in your benefits. We will tell you in advance if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2024.

At any time during the year, the Original Medicare program can change its national coverage. Since, with a few exceptions, we cover what Original Medicare covers, we would have to make

any change that the Medicare program makes. These changes could increase or decrease your benefits, depending on what change the Original Medicare program makes.

Section 3 Medical emergencies and urgent need for care

The difference between a medical emergency and urgently needed services

The main difference between a medical emergency and an urgent need for care is the danger to your health.

- It is urgently needed services if you need medical help immediately, but your health is not in serious danger.
- It is a medical emergency if you believe that your health is in serious danger?

What is a medical emergency?

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

What should you do if you have a medical emergency?

Get help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital or urgent care center. Call an ambulance if you need it. You do not need to get permission first from a SFEHACL in-network provider. You are expected to get care immediately regardless of the providers' participation status.

What is covered if you have a medical emergency?

You can get covered emergency medical care whenever you need it, anywhere in the U.S. Ambulance services are covered in situations where other means of transportation would endanger your health.

SFEHACL Medicare Secondary Plan payment for medical emergency care

You are <u>not</u> required to go to SFEHACL in-network providers when you have a medical emergency to receive Original Medicare benefits.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real 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 was not a medical emergency after all. If this happens to you, you are still covered for the care you received to determine what was wrong, as long as you thought your health was in serious danger as explained above in *What is a medical emergency?*

What is urgently needed services?

Urgently needed services (different from a medical emergency) is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

If you have a sudden illness or injury that is not a medical emergency, and you have SFEHACL in-network providers available to you, we expect you to get this care from in-network providers. Remember that SFEHACL has a vast national in-network provider network.

Getting care during a disaster.

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

Please visit the SFEHACL website santafeha.com for information on how to obtain needed care during a disaster.

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

Section 4 Medical benefits chart—A list of covered services

What are covered services?

Covered services mean the medical care, services, supplies, and equipment that are covered by Original Medicare and/or your SFEHACL Medicare Secondary Payer plan (MSP). The Benefits Chart in this Section provides a summary of benefits under Original Medicare Part A and B and the SFEHACL MSP. Please continue to use your *Medicare and You* handbook for additional details. This chart does not describe all covered benefits or exclusions under Original Medicare or the SFEHACL Medicare Secondary Plan. This chart does not take the place of laws, rules, or regulations under either program.

Section 5 that follows tells about services that are not covered (also called exclusions). If you have problems with getting Medicare services that you believe are covered, please see Sections 10 and 11.

There are some conditions that apply in order to get covered services and some general requirements apply to all covered services. The covered services listed in the Benefits Chart in this Section are covered only when all requirements listed below are met:

- You receive your Medicare benefits through Original Medicare Parts A and B. Services must be provided according to Original Medicare coverage guidelines established by the Medicare program and to SFEHACL guidelines for MSP coverage.
- Your services including medical care, services, supplies, and equipment must be medically necessary. Medically necessary means that the services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your medical condition must meet accepted standards of medical practice.
- Covered services should be provided by SFEHACL in-network providers to receive maximum MSP benefits. Original Medicare benefits do not change when you obtain services from providers who do not participate with SFEHACL.
- If Medicare adds coverage under Original Medicare for new services during the current year, they will be covered under your Original Medicare plan, however they may not be covered under the SFEHACL plan.
- When you obtain services from non-Medicare participating providers, Medicare reduces benefit payment. You pay the remaining approved amounts or more up to the Medicare limiting amount, which is 115% of the Medicare approved amount if the provider does not accept Medicare assignment.
- The Medicare deductible is the annual amount Original Medicare Part A and B requires you to pay for the health care services you receive. SFEHACL MSP pays your annual Medicare deductibles in full.

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This symbol next to the type of service in the Benefit Chart indicates a preventive service or screening under Original Medicare.

Medical Benefits Chart

The following pages give an alphabetical summary list of your Medicare benefits and your SFEHACL Medicare Secondary Plan benefits. It is not meant to be a comprehensive list of all benefits and all details of the benefits listed, nor a replacement for your *Medicare and You* book. You may need to use both books together.

PREVENTIVE SERVICES

BENEFIT: Medicare covers many preventive services to help you stay healthy. Use this list to keep track of the services you need and when you need them. Talk with your health care provider about which of these services is right for you. See your Medicare and You book for a detailed explanation of rules for these services.

Payment: Medicare pays 100% if the doctor accepts assignment. Any related services as a result of these services could have a deductible and copayment applied if approved. In-network related services are paid by SFEHACL at 100% after Medicare.

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Medicare-Covered Preventive Service	Needed / When	Date of service
Welcome to Medicare preventive visit (one-time)		
Yearly Wellness visit		
Abdominal aortic aneurysm screening		
Alcohol misuse screening and counseling		
Bone mass measurement (bone density)		
Breast cancer screening (mammogram)		
Cardiovascular disease risk reduction		
Cardiovascular disease testing		
Cardiac rehabilitation services		
Cervical and vaginal cancer screening		
Colorectal cancer screenings		
Guaiac test, FIT test and DNA colorectal testing		
Screening flexible sigmoidoscopy		

Screening colonoscopy, barium enema		
Depression screening		
Diabetes screening		
Diabetes self-management training		
Diabetes Prevention Program (MDPP)		
Glaucoma test		
Hepatitis B shot, Flu shot		
Hepatitis C screening test		
HIV screening		
Screening for Lung Cancer screening with low dose Computed Tomography (LDCT)		
Medical nutrition therapy services		
Obesity screening and therapy		
Pneumococcal shot		
Prostate cancer screening		
Sexually transmitted infections screening and counseling		
Smoking and Tobacco use cessation counseling.		

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WELCOME TO MEDICARE PREVENTIVE VISIT (one time)

BENEFIT: Medicare covers a one-time Welcome to Medicare Physical Exam during the first 12 months you have Part B. The exam includes a review of your health, as well as education and counseling about the preventive services you need including screenings, shots and referrals for other care if needed.

If you have had Part B for longer than 12 months, you can get a yearly Wellness visit to develop or update a personalized prevention plan based on your current health and risk factors.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 100% if the doctor accepts assignment. Any related services as a result of the screening could have a deductible and coinsurance applied if approved.	SFEHACL pays the coinsurance and deductible amounts not paid by Medicare for any related approved services as a result of the screening. You pay $0. You pay all services not approved by Medicare.

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ANNUAL WELLNESS VISIT

BENEFIT: If you've had Part B for longer than 12 months, you can get a Yearly 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.

Note: Your first Yearly Wellness visit can't take place until after 12 months of your enrollment in Part B. Your Welcome to Medicare visit is done in the first 12 months. You don't need to have the Welcome to Medicare visit to be covered for Yearly Wellness visits after you have had Part B for 12 months.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 100% if the doctor accepts assignment. Any related services as a result of the screening could have a deductible and coinsurance applied if approved.	SFEHACL pays the coinsurance and deductible amounts not paid by Medicare for any related approved services as a result of the screening. You pay $0. You pay all services not approved by Medicare.

ACUPUNCTURE FOR CHRONIC LOW BACK PAIN

BENEFIT: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances.
For the purpose of this benefit, chronic low back pain is defined as

- Lasting 12 weeks or longer.
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease.
- Not associated with surgery or pregnancy.

An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatment may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	SFEHACL pays all approved amounts for Acupuncture not paid for by Medicare. See the above stipulations. You pay all services not approved by Medicare.

AMBULANCE SERVICES

BENEFIT: Medicare covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency transport in an airplane or helicopter to a hospital if you need immediate and rapid transportation that ground transportation either cannot provide or could endanger your health.

Non-emergency transportation by ambulance is appropriate if it is documented that the member's medical condition is such that other means of transportation could endanger your health.

Medicare will only cover transportation to the nearest appropriate medical facility that is able to give you the care you need.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay all amounts for services that are not allowed by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services that are not allowed by Medicare.

BLOOD TRANSFUSION (possible Part A or Part B benefit)

BENEFIT: If the Part A hospital and/or provider get blood from a blood bank at no charge, you won't have to pay for it or replace it. If Part B, you will pay a coinsurance for the blood processing and handling services for each unit of blood and the Part B deductible applies. If the (Part A or Part B) hospital and/or provider have to buy blood for you, you must either pay the providers costs for the first 3 units of blood you get in a calendar year or have the blood donated by you or someone else.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
See above for stipulations and Medicare payment.	SFEHACL pays all approved amounts for blood not paid for by Medicare. See the above stipulations. You pay all services not approved by Medicare.

CARDIAC REHABILITATION SERVICES

BENEFIT: Medicare covers comprehensive programs with a doctor's referral that include exercise, education and counseling for members who meet one or more of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (to open a blocked artery) or coronary stenting to keep an artery open
- A heart or heart/lung transplant

Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular programs. Services are covered at a doctor's office or outpatient setting.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part B annual deductible and 20% of the approved	Medicare limits apply. SFEHACL pays the Part B annual deductible and/or the approved

amounts not paid by Medicare. You pay all services not approved by Medicare.	amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

CHEMOTHERAPY

BENEFIT: Medicare covers chemotherapy administered in a doctor's office, freestanding clinic, and hospital outpatient and hospital inpatient setting for people with cancer.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 80% for chemotherapy given in a doctor's office or freestanding clinic. You pay 20% of the Medicare approved amount. You pay a copayment for chemotherapy in a hospital outpatient setting. Chemotherapy provided in a hospital inpatient setting is covered under Part A.	SFEHACL pays the deductible and coinsurance for the approved amount for chemotherapy. You pay all services not approved by Medicare.

CHIROPRACTIC SERVICES

BENEFIT: Medicare covers these services to help correct a subluxation (when 1 or more of the bones of your spine move out of position) using manual manipulation of the spine to correct the subluxation when provided by a chiropractor or other qualified provider.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all costs for any other services or tests ordered by a chiropractor (including x-rays and massage therapy), and routine chiropractic services.	SFEHACL pays Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

CLINICAL RESEARCH STUDIES

BENEFIT: National Coverage Determinations (NCDs) and Investigational device trials (IDE) and Clinical research studies test how well different types of medical care work and if they're safe. Medicare covers some costs, like office visits and tests in qualifying clinical research studies.

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

Original Medicare Part A and B Benefits	Secondary Plan Benefits

You may pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

DEFIBRILLATOR (implantable automatic)

BENEFIT: Medicare covers these devices for some people diagnosed with heart failure. If the surgery takes place in an outpatient setting, Part B rules and deductible apply. If the surgery takes place in a hospital inpatient setting, they are covered under Medicare Part A rules.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 80% if billed under Part B and the deductible applies. Hospital inpatient rules apply under Part A.	SFEHACL pays the Part A and B coinsurance and deductible approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

DENTAL SURGERY

BENEFIT: Medicare benefits are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor. Dental services such as cleaning, exams, fillings, and dental x-rays, etc. are not a covered benefit under Medicare or SFEHACL.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. Routine dental services are not a covered benefit.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. Routine dental services are not a covered benefit. You pay all services not approved by Medicare.

DIABETES SUPPLIES

BENEFIT: Medicare covers blood glucose testing monitors, test strips, lancet devices and lancets and blood sugar control solutions for checking the accuracy of monitors. Medicare only covers insulin under Part B if used with an external insulin pump. Medicare Part D prescription drug plans may cover insulin, oral diabetic drugs, and certain supplies such as syringes. Medicare may cover therapeutic shoes for people with severe diabetic foot disease. If covered, Medicare would pay each calendar year for one pair of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare.	SFEHACL pays the Part B annual deductible and the approved amounts not paid by

	Medicare. You pay all services not approved by Medicare.

DOCTOR AND OTHER HEALTH CARE PROVIDER SERVICES

BENEFIT: Medicare covers medically necessary doctor services furnished in a doctor's office, certified ambulatory surgical center, hospital outpatient department, or any other location including:

- Inpatient physician medical and surgical services
- Certain drugs and biologicals that you can't give yourself that are given in the doctor's office
- Consultation, diagnosis, and treatment by a specialist
- Second opinion prior to surgery
- Covered preventive and screening services
- Services provided by other health care providers like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of the approved amount not paid by Medicare except for certain preventive services. NOTE: SFEHACL HCPP processes Original Medicare Part B claims for in-network physician office visits and office services, consultations, hospital visits, and surgical procedures.	SFEHACL pays the Part B annual deductible and/or the approved amount not paid by Medicare. You pay $0. NOTE: SFEHACL HCPP processes Original Medicare Part B claims for in-network physician office visits and office services, consultations, hospital visits, and surgical procedures. You pay all services not approved by Medicare.

DRUGS COVERED BY MEDICARE PART B

BENEFIT: Medicare covers the following drugs under Part B. Sometimes the drug can be covered by Part D when not covered by Part B or when Part A benefits are exhausted. Medicare Part A covers payment for most drugs at the hospital or skilled nursing facility (SNF) during a covered stay. Part B covered drugs include:

- Shots: Flu, Hepatitis B and Pneumococcal, Covid vaccine and Monoclonal Antibodies
- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers)
- Clotting factors, you give yourself by injection if you have hemophilia getting physician, hospital outpatient or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers)
- Clotting factors, you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens

- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the applicable inpatient deductible and copayments for Medicare Part A. You pay the applicable deductible and copayments not paid by Medicare Part B. Medicare does not pay for other items and services related to getting IVIG at home.	SFEHACL pays the approved amounts not paid by Medicare. You pay $0. You pay all amounts not approved by Medicare.

DURABLE MEDICAL EQUIPMENT (DME)

BENEFIT: Medicare covers items like oxygen equipment and supplies, delivery of oxygen and oxygen contents, tubing and related oxygen accessories for the delivery of oxygen and maintenance and repairs of equipment, wheelchairs, walkers, and hospital beds ordered by a doctor or other healthcare provider enrolled in Medicare for use in the home. Some items must be rented. You must get your covered equipment or supplies and replacement or repair services from a Medicare-approved supplier for Medicare to pay. For a definition of "durable medical equipment," see section 13 of this document.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay the remaining amounts for non-covered items.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

COMPETITIVE BIDDING PROGRAM—DME, PROSTHETICS AND ORTHOTIC (DMEPOS)

BENEFIT: You have Original Medicare and if you live in a Competitive Bidding Area (CBA) and use equipment or supplies included under the program (or get them while visiting a CBA), you generally must use Medicare contract suppliers if you want Medicare to help pay for them. Visit medicare.gov/medical-equipment-suppliers/?redirect=true to determine if you live in a CBA and to find Medicare-approved suppliers in your area. If your ZIP code is in a CBA, the items included in the program are marked with an orange star. You can also call Medicare at 1-800-633-4227.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by

Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment or is not in an applicable CBA ZIP code.	Medicare. You pay all services not approved by Medicare.

EMERGENCY DEPARTMENT SERVICES

BENEFIT: These services are covered when you have an injury, a sudden illness, or an illness that quickly gets much worse. Emergency services are services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay 20% of the approved amount not paid by Medicare for each emergency room visit. You do not pay this amount if you are admitted to the hospital for the same condition within 1-3 days of the emergency room visit. You also pay 20% of the approved doctor amount not paid by Medicare.	SFEHACL pays the approved amount not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

EYEGLASSES (Limited coverage)

BENEFIT: Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or the supplier). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare

FOOT EXAMS AND TREATMENTS

BENEFIT: Medicare covers foot exams and treatment if you have diabetes-related nerve damage and/or if you meet certain conditions. Covered are the diagnosis and medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of the approved amount not paid by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare

HEARING AND BALANCE EXAMS

BENEFIT: Medicare covers these exams if your doctor or other health care provider orders them to see if you need medical treatment. Medicare does not cover hearing aids or exams for fitting hearing aids. Routine hearing examinations are not a covered benefit by Medicare. SFEHACL through Amplifon offers hearing exams and hearing aids.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. Routine hearing examinations are not a covered benefit by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. For routine care you pay the copay depending on the hearing aid you choose through Amplifon.

HOME HEALTH SERVICES (Part A benefit)

BENEFIT: Medicare covers medically necessary part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for people with a continuing need for occupational therapy. A doctor or certain other health care professionals who work with a doctor must see you face-to-face before a doctor can certify that you need home health services. A doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment and medical supplies for use at home. You must be homebound, which means both of the following apply to you:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home is not recommended because it's a major effort.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays all approved amounts for approved visits. You pay all amounts for non-approved visits. For medical equipment used during home health, you pay the Part B annual deductible plus 20% of approved amounts.	Medicare pays all approved amounts. You pay $0 for approved visits. You pay all amounts for non-approved visits. You pay all services not approved by Medicare

HOME INFUSION THERAPY (Part B benefit)

BENEFIT: Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).

Covered services include, but are not limited to: Professional services, including nursing services, furnished in accordance with the plan of care. Patient training and education not otherwise covered under the durable medical equipment benefit. Remote monitoring, monitoring

services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays all approved amounts. You pay all amounts for non-approved visits. For medical equipment used during IV infusion, you pay the Part B annual deductible plus 20% of approved amounts.	Medicare pays all approved amounts. You pay $0 for approved visits. You pay all services not approved by Medicare.

HOSPICE CARE (Part A benefit)

BENEFIT: When your doctor certifies that you are terminally ill and expected to live 6 months or less, you may receive care from any Medicare-certified hospice program. If you are already getting Hospice care, a hospice doctor or nurse practitioner will need to see you about 6 months after you enter hospice to certify that you are still terminally ill. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment; as well as services Medicare, usually doesn't cover like spiritual and grief counseling. A Medicare approved hospice usually gives hospice care in your home or other facility where you live like a nursing home. Your hospice doctor can be a network provider or an out-of-network provider.

The Medicare program has written a document about Medicare Hospice Benefits. To get a free copy call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare Website at medicare.gov. Section 1 tells more about how to contact the Medicare program.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay nothing for hospice care. You must receive care from any Medicare-certified hospice. You pay 5% of the Medicare-approved amount for inpatient respite care. You pay $5 per prescription for outpatient prescription drugs for pain and symptom management. These drugs are not covered under Part D.	SFEHACL pays the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

HOSPITAL INPATIENT SERVICES (Part A benefit)

BENEFIT: Medicare Part A covered service while you are an inpatient in a hospital include but are not necessarily limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications while you are an inpatient
- Lab tests

- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.

Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! Available by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
The 2024 Medicare deductible and copayment amounts were not yet released at the time this document was printed. Please see your *Medicare and You* handbook or call 1-800-Medicare (1-800-633-4227).	SFEHACL pays the approved amount not paid by Medicare for each benefit period and/or daily coinsurance. You pay $0. You pay all hospital costs for each day beyond 150 days. You pay all services not approved by Medicare.

INPATIENT SERVICES IN A PSYCHIATRIC HOSPITAL (Part A benefit)

BENEFIT: Medicare covers Inpatient services in a psychiatric hospital. Medicare benefits are the same as hospital inpatient care, except there is a 190-day lifetime limit in a freestanding psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay all approved amounts not paid by Medicare.	SFEHACL Healthcare pays the Part A annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

INPATIENT COVERED SERVICES RECEIVED IN A HOSPITAL OR SNF DURING A NON-COVERED INPATIENT STAY

BENEFIT: If you have exhausted your Part A inpatient benefits or if your hospital inpatient stay is not reasonable and necessary, Medicare will not cover your inpatient stay. In some cases, Medicare will cover certain services you receive while you are in the hospital or the nursing facility (SNF). Medicare covered services may include:

- Physician services
- Diagnostic tests (like lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of the approved amount not paid by Medicare. You pay any services not paid by Medicare.	When a covered benefit, SFEHACL pays Part B annual deductible and /or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION

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

Original Medicare Part A and B Benefits	Secondary Plan Benefits
To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted." "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not*	To be covered by the SFEHACL 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.

required by any federal, state, or local law. "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.	Our plan's coverage of services you receive is limited to *non-religious* aspects of care. If you get services from this institution that are provided to you in a facility, the following: You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care. You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered. You pay all services not approved by Medicare.

KIDNEY DIALYSIS SERVICES AND SUPPLIES AND KIDNEY DISEASE EDUCATION

BENEFIT: Generally, Medicare covers up to 3 outpatient dialysis treatments per week (including dialysis treatments when temporarily out of the service area) if you have End Stage Renal Disease (ESRD). This includes all ESRD-related drugs and biologicals, laboratory tests, home dialysis training, supportive services, equipment and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). Up to 6 sessions of kidney disease education services. You must have Stage IV chronic kidney disease and your health care provider must refer you for this service.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible plus 20% of approved amounts not paid by Medicare. Medicare pays for blood tests and you pay $0.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

LABORATORY SERVICES

BENEFIT: Medicare covers laboratory services including certain blood tests, urinalysis and some screening tests when ordered by your health care provider.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 100% if the doctor is participating with Medicare.	Medicare pays 100%. You pay $0. You pay all services not approved by Medicare.

MENTAL HEALTH CARE (Outpatient-limited)

BENEFIT: Medicare covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor office or hospital outpatient department). Coverage includes visits with a psychiatrist, other doctor, clinical psychologist, nurse practitioner, physician assistant, clinical nurse specialist or clinical social worker, licensed marriage and family therapist (LMFT), licensed professional counselor in accordance with the Consolidated Appropriations Act of 2023 visits to a doctor to diagnose your condition or monitor your prescriptions. Laboratory tests are also covered. Certain limits and conditions apply. Note: Inpatient mental health care is covered under Medicare Part A.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays 80% and the Part B deductible applies.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay the amounts not paid by Medicare.

OUTPATIENT HOSPITAL SERVICES, MEDICAL AND SURGICAL SERVICES AND SUPPLIES

BENEFIT: Medicare covers many diagnostic and treatment services in participating hospital outpatient departments. These are usually paid at 80% of the approved amount. Medicare covers approved procedures like X-rays, casts, stitches, or outpatient surgeries. You may pay more for services you get in a hospital outpatient setting than you will pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you will usually pay the hospital deductible or coinsurance except for certain preventive services.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare pays some screening and preventive service at 100%. For other services, you may pay the Part B annual deductible plus 20% of the approved amount not paid by Medicare for the physician and hospital services.	SFEHACL pays the Part B annual deductible and/or the approved amount not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

OUTPATIENT SURGERY, SURGICAL DRESSING SERVICES AND SERVICES PROVIDED AT AMBULATORY SURGICAL CENTERS AND HOSPITAL OUTPATIENT FACILITIES

BENEFIT: Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Ambulatory surgical center services must be Medicare approved. Medicare generally covers surgical dressing services for treatment of a surgical or surgically treated wound.

Original Medicare Part A and B Benefits	Secondary Plan Benefits

You pay the Part B annual deductible plus 20% of the approved amounts not paid by Medicare. You pay all facility charges for procedures Medicare doesn't allow to be done in ambulatory surgical centers. When you get surgical dressing services you pay nothing for the supplies and the Part B deductible applies.	SFEHACL pays the Part B annual deductible and the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

PARTIAL HOSPITALIZATION SERVICES

BENEFIT: Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and the portion of the approved amounts not paid by Medicare.	SFEHACL Healthcare pays the Part B annual coinsurance and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH LANGUAGE PATHOLOGY SERVICES

BENEFITS: Medicare covers evaluation and treatment for injuries and diseases that change your ability to function when your doctor certifies your medical need for it. There may be a limit on the amount Medicare will pay for a single year and there may be exceptions to the limits. Covered services could include evaluation and treatment to help you perform activities of daily living (like dressing or bathing) after an illness or accident, evaluation and treatment given to regain and strengthen speech and language skills, including cognitive and swallowing skills. Outpatient rehabilitation services are provided in various outpatient settings, such as hospitals, doctor's offices, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	Medicare limits apply. SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

PROSTHETIC, ORTHOTIC DEVICES AND RELATED SUPPLIES

BENEFIT: Medicare covers devices (other than dental) that replace a body part or function. These include, but are not limited to: arm, neck, leg and back braces; artificial eyes; artificial limbs; colostomy bags and supplies directly related to colostomy care, pacemakers, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. One

pair therapeutic shoe per calendar year for those with diabetic foot disease. Note: To get enteral nutrition therapy in most areas of the country, you generally must use specific suppliers called "contract supplier" or Medicare won't pay, and you'll likely pay the full price.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay for all amounts above Medicare approved amounts if the provider does not accept assignment. You pay the remaining amounts for non-covered items.	When a covered benefit, SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay all services not approved by Medicare.

PULMONARY REHABILITATION

BENEFIT: Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) with an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	Medicare limits apply. SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

RURAL HEALTH CLINIC SERVICES

BENEFIT: Rural health clinics (RHCs) furnish many outpatients primary care and preventive health services. RHCs are located in non-urban areas that are medically underserved or shortage areas.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

SKILLED NURSING FACILITY CARE (Part A benefit)

BENEFIT: Skilled nursing facilities are sometimes called SNFs. Medicare covers semi-private rooms, skilled nursing and rehabilitative services and other medically necessary services and supplies after a 3-day minimum medically necessary inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital formally admits you as an inpatient and doesn't include the day you are discharged. To qualify for care in a SNF, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy. Medicare doesn't cover long-term services or custodial care.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
The 2024 deductible and coinsurance amounts were not yet released by Medicare at the time this document was printed. Please see your Medicare & You handbook or call 1-800-Medicare. You pay nothing for the first 20 days of each benefit period. You pay coinsurance per day for days 21-100 each benefit period. You pay all costs for each day after day 100 in a benefit period.	SFEHACL pays the approved amount not paid by Medicare up to a lifetime maximum of $8000.

TELEHEALTH

BENEFIT: Medicare covers limited medical or other health services such as office visits and consultations provided using an interactive, two-way telecommunications system (real-time audio and video) by an eligible provider who isn't at your location. These services are available in some rural areas, under certain conditions, and only if you're located at: a doctor's office, hospital, rural health clinic, federally qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. If plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

TESTS (Other than laboratory tests)

BENEFIT: Medicare covers X-rays, MRIs; CT scans, EKGs, and some other diagnostic tests that are medically necessary and ordered by your doctor. If you get the tests at a hospital as an outpatient, you also pay the hospital a copayment that may be more than 20% of the Medicare approved amount.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You may pay more than the 20% at some hospital outpatient sites.	SFEHACL pays the Part B annual deductible and/or the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

TRANSPLANTS AND IMMUNOSUPPRESSIVE DRUGS

BENEFITS: Medicare covers hospital and doctor services for heart, lung, kidney, pancreas, intestine and liver transplants under certain conditions and only in a Medicare-certified facility.

Medicare covers bone marrow and corneal transplants under certain conditions. Medicare covers immunosuppressive drugs if the transplant was eligible for Medicare payment or an employer or union group health plan was required to pay before Medicare paid for the transplant. You must have Part A at the time of the transplant, and you must have Part B at the time you get immunosuppressive drugs. Part D may cover immunosuppressive drugs, even if Medicare didn't pay for the transplant.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay 20% of the approved amount and the Part B deductible. Medicare pays 100% if the doctor or health care provider accepts assignment. You may pay a copayment for Part D drugs.	SFEHACL pays the approved amounts not paid by Medicare. You pay $0 except for Part D copayments when applicable. You pay all services not approved by Medicare.

TRAVEL (Healthcare needed when traveling outside the U.S.)

BENEFIT: Medicare generally doesn't cover health care while you're traveling outside the U.S. The U.S. includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. There are some exceptions, including cases where Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in the following rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs. The Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S hospital that can treat your medical condition, regardless of whether an emergency exists.
- Medicare may cover medically necessary ambulance transportation to a foreign hospital only with admission for medically necessary covered hospital inpatient services.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
Medicare limits apply. You pay the Part A annual deductible and coinsurance and the Part B annual deductible and 20% of the approved amounts not paid by Medicare. You pay all services not approved by Medicare.	Medicare limits apply. SFEHACL pays the Part A annual deductible and coinsurance and the Part B annual deductible and coinsurance of the approved amounts not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

URGENTLY NEEDED CARE

BENEFIT: Medicare covers urgently needed services to treat a sudden illness or injury that isn't a medical emergency. Services must be medically necessary. Sometimes it may not be reasonable, given the circumstances, to obtain the services through a SFEHACL in-network provider. Services must be obtained in the United States.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the deductible and 20% of the approved amounts not paid by Medicare. In a hospital outpatient setting, you pay the hospital a copayment. Not covered outside the United States except under limited circumstances.	SFEHACL pays the approved amount not paid by Medicare. You pay $0. You pay all services not approved by Medicare.

VISION CARE AND GLAUCOMA TESTS

BENEFIT: Medicare covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, diabetics, Hispanics who are 65 or older, African Americans who are age 50 and older, glaucoma screening is approved once per year.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. For people with diabetes, screening for diabetic retinopathy is covered once per year.

Original Medicare Part A and B Benefits	Secondary Plan Benefits
You pay the Part B annual deductible and 20% of the approved amounts not paid by Medicare. Glaucoma tests must be performed by an eye doctor who's legally allowed by the state to do the tests. Refractive surgery is not a Medicare benefit. The refractive portion of the medical eye exam is not a Medicare benefit. Routine eye exams are not a Medicare covered benefit.	SFEHACL pays the Part B annual deductible and the approved amounts not paid by Medicare. SFEHACL covers one refractive portion of a medical eye exam ($45.00) annually that is not covered by Medicare. Payment amount is the SFEHACL plan allowable amount. You pay all other services not approved by Medicare

Section 5 Medical care and services that are not covered

This Section tells you what kinds of benefits are excluded. Excluded means that none of these services are covered by Original Medicare and/or SFEHACL. The list below tells about these exclusions and limitations. The list describes services that are not covered under any conditions, and some services that are covered only under specific conditions. The Medical Benefits Chart in Section 4 also explains some restrictions or limitations that apply to certain services.

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this Section (or elsewhere in this document), and neither will Original Medicare unless they are found upon appeal to be services that Original Medicare should have paid or covered. For more information on appeals, see Section 10.

Benefit exclusions

If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. This information provides a summary of benefit exclusions under Medicare Parts A and B, the SFEHACL HCPP, and the SFEHACL Medicare Secondary Plan. This summary does not describe all benefits or exclusions under Original Medicare, or the SFEHACL Medicare Secondary Plan. This summary does not take the place of laws, rules, or regulations under any of these programs.

There are some benefits that are not covered by Original Medicare that are covered benefits through the SFEHACL Medicare Secondary Plan.

Original Medicare excluded benefits

Neither Original Medicare nor SFEHACL MSP will pay for the exclusions that are listed in this Section (or elsewhere in this book). The following services and supplies are not covered under Original Medicare:

1. Medicare approved Part D outpatient prescription drugs under your Medicare Part D plan.
2. Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by SFEHACL as covered services.
3. Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. Experimental procedures and items are those items and procedures determined by Original Medicare and SFEHACL to not be generally accepted by the medical community.
4. Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
5. Private room in a hospital, except when it is considered medically necessary.
6. Private duty nurses.
7. Personal items in your room at a hospital or a skilled nursing facility that include extra charges, such as WI-FI or other digital services.
8. Full-time nursing care in your home.
9. Custodial care that is provided in a nursing home, hospice or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal

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

10. Homemaker services including basic household assistance, including light housekeeping or light meal preparation.
11. Fees charged by your immediate relatives or members of your household.
12. Meals delivered to your home.
13. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, and anti-aging procedures), except when medically necessary and approved by Medicare.
14. Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
15. Routine dental care, such as cleanings, filings, or dentures. However, non-routine dental care received to treat illness or injury may be covered as inpatient or outpatient care.
16. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines. Chiropractic care is limited according to Medicare guidelines. (See Medical Benefits Chart in Section 4.)
17. Routine foot care, except for the limited coverage provided according to Medicare guidelines.
18. Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
19. Eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, one pair of eyeglasses is covered for people after cataract surgery. The SFEHACL MSP provides limited coverage for routine eye exams (see Medical Benefits Chart in Section 4).
20. Routine doctor visits or examinations that are not covered by Original Medicare, or SFEHACL.
21. Reversal of sterilization procedures, gender reassignment surgery (sometimes allowed by Medicare), and non-prescription contraceptive supplies.
22. Naturopath services (uses natural or alternative treatments).
23. Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under Medicare, we will reimburse veterans at the out-of-network provider amount for the difference. Members are still responsible for our cost-sharing discounts for out-of-network providers.
24. Transportation.

SFEHACL Medicare Secondary Plan excluded benefits

Even though some of these items, services, or circumstances could be a covered benefit under your Original Medicare benefits, they are excluded benefits under your SFEHACL Medicare Secondary Plan. If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. We do not pay for the exclusions that are listed in this Section (or elsewhere in this book).

The SFEHACL Medicare Secondary Plan excludes the following benefits in addition to Medicare excluded benefits:

1. Members who abuse the benefits, or rules and regulations of SFEHACL may be excluded from further benefits even though Original Medicare may continue coverage.
2. Pensioned Members who are eligible for Medicare are not permitted to duplicate benefits under any other SFEHACL plan.
3. Payment for services provided in a United States government, hospital or through the provisions of state Medicaid including MediCal programs will not be duplicated by any SFEHACL plans.
4. Payment for on-duty injuries sustained while in the employment of some person, firm, company, self-employment, or organization other than the SFRR and/or subsidiaries and affiliated companies will be excluded.

SFEHACL Enhanced Benefits

Even though Medicare denies these benefits SFEHACL offers enhanced coverage for the services listed below.

Hearing benefits are offered through Amplifon Hearing Health Care Program. Contact Amplifon at 1-855-680-8178 (Toll free) or www.amplifonusa.com/lp/santafeha

Your hearing coverage:

- Free hearing exam with an Amplifon provider
- Hearing aids for copayments listed below

TIER	MEMBER OUT OF POCKET
1	$695 copay per hearing aid
2	$995 copay per hearing aid
**	*Other options are available at a higher copay

Aftercare package:

- 2 years free batteries or a recharging station
- 3-year loss and damage warranty (deductible of $150 to $250 to replace)
- 60-day risk free trial period
- 12-month interest free financing options
- 1 year free follow up care with provider.

Section 6 Prescription drugs, diabetic supplies, and insulin

Part D Prescription Drug Program administered by Optum Rx

The SFEHACL Part D prescription drug plan is administered by Optum Rx. Optum Rx is contracted with the Centers for Medicare & Medicaid Services (CMS). All SFEHACL Medicare HCPP members are also members of the SFEHACL Part D plan. As a current SFEHACL Medicare member, we have automatically enrolled you in this plan so that we can continue to provide your prescription drug benefits.

Your enrollment in the Part D Prescription Drug Plan does not affect coverage of drugs under Original Medicare Part A or Part B. If you meet Original Medicare's coverage requirements, those eligible drugs are still covered even though you are enrolled in our Part D prescription drug plan. Some drugs may be covered under Medicare Part A, Part B, or under Medicare Part D, but never all at the same time. Usually, your pharmacist or provider will determine whether to bill Medicare Part B or Part D for the drug in question.

Most Medicare Part D drugs are available to you and are included in the SFEHACL formulary.

Diabetic supplies, insulin, and syringes

Your Original Medicare Part B benefits include medical coverage of a blood glucose monitor, diabetic test strips, lancets and insulin used in an insulin pump. Medicare considers these items to be medical benefits and not pharmacy benefits, even though they are usually obtained from pharmacies.

Medicare benefits limit the number of diabetic test strips and lancets that are usually covered. An insulin treated diabetic is allowed 300 each of test strips and lancets (testing three times a day) for a three-month supply; and a non-insulin treated diabetic is allowed 100 each of test strips and lancets (testing once a day) for a three-month supply.

Your Part D Medicare Prescription Drug Plan includes coverage of diabetic insulin, alcohol swabs and syringes as a Medicare Part D benefit. See your Medicare Part D Evidence of Coverage for more information.

Section 7 What you must pay for the SFEHACL Medicare Plan and your care

Paying the plan premium for your coverage as a member of the SFEHACL Medicare Plans

The monthly premium amount for 2024 is listed in your 2024 Annual Notice of Changes. Premium payments for membership in the SFEHACL Medicare Plans include the Medicare Secondary Plan and the SFEHACL Prime Medicare Plan Part D prescription plan, administered by OptumRx. You pay no premium for your HCPP membership because that premium is included in your payment for Medicare Part B. Members must continue to pay the Medicare Part B monthly premium. All SFEHACL Medicare members must be entitled to Medicare Part A and enrolled in Part B. If you pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. Premiums are paid monthly or quarterly (three months at a time) to SFEHACL.

There is no additional or separate fee for membership in the SFEHACL HCPP because you have Original Medicare Part B and pay those monthly premiums. The SFEHACL Medicare HCPP makes the Original Medicare Part B payment to in-network physicians. This is why CMS only authorizes SFEHACL to make payment of HCPP benefits if you are enrolled in Original Medicare Part B. Premiums that are paid to SFEHACL are for membership in the SFEHACL Medicare Part D prescription plan and the SFEHACL MSP. The SFEHACL MSP pays the annual deductible and coinsurance after Original Medicare Part A and B have paid.

You must continue to pay your Medicare Part B premium

You must continue to pay your Medicare Part B monthly premium. Your SFEHACL MSP and Part D Medicare Plan premiums are combined and paid to SFEHACL in addition to payment of your Original Medicare Part B premiums.

Can we change your monthly plan premium during the year?

Premium amounts are determined by the SFEHACL Board of Trustees and generally will not change during a plan year. If the monthly premium changes for next year, we will notify you in the ANOC (Annual notice of change) you receive in October and the change will take effect on January 1 of the following year.

- In some cases, the Part D portion of your premium can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the monthly plan premium. So, a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. A member who loses their eligibility during the year will need to start paying their full monthly premium.
- In some cases, you may need to start paying or may be able to stop paying a Part D late enrollment Penalty. The Part D late enrollment Penalty may apply if you had a continuous period of 63 days or more when you did not have creditable prescription drug coverage. This could happen if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year:
    - If you currently pay the Part D late enrollment Penalty and become eligible for Extra Help during the year, you would no longer pay your penalty.

- If the Extra Help program is currently paying your Part D late enrollment Penalty and you lose your eligibility during the year, you would need to start paying your penalty.

There are two ways to pay your monthly plan premium.
SFEHACL charges a $20 service fee for any premium payments rejected for any reason.

- Option One – Quarterly: Pay your plan premium quarterly (3 months at a time) by check, or money order. If you pay by check or money order, we must receive your payment by the first of the month - January, April, July, and October beginning with January 1, 2024.

- Option Two – Monthly: Pay your plan premium monthly by check, money order or automatic premium deduction from your checking or savings account, we will debit your account on the 15th day of every month.

If you have any questions about signing up for the automatic premium payment option, to receive an authorization form, or different ways to pay them, please call Member Services at 1877-968-3550, TTY call 711.

What happens if you don't pay your SFEHACL plan premiums, or don't pay them on time?
If your Plan premiums are past due, we will tell you in writing within 15 days. Medicare requires us to disenroll you in our plan after the second month of failure to pay your past-due plan premiums. If you are disenrolled from SFEHACL for any reason including nonpayment of your premium, you may not have another opportunity to enroll again. Disenrolling ends your membership in the SFEHACL HCPP, the Medicare Secondary Plan and the SFEHACL Medicare Part D prescription drug plan administered by Optum Rx and you may not be allowed to enroll again. You will then have Original Medicare coverage. (Section 11 explains about disenrollment and Original Medicare coverage.)

In some situations, your plan premium could be less
You pay a combined MSP and Part D premium. There are programs to help people with limited resources pay for their Part D premiums and drugs. These include Extra Help and State Pharmaceutical Assistance Programs.

If you are already enrolled and getting help from one of these programs, the information about premiums in the Annual Notice of Changes and this Evidence of Coverage may not apply to you. We send a separate insert called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (LIS Rider) which tells you about your drug coverage and your monthly premiums. If you don't have this insert, our records indicate that these programs do not apply to you.

In some situations, your plan premium could be more
In some situations, your plan premium could be more than the amount listed in the Annual Notice of Changes.

- Most people pay a standard monthly Part D premium (combined with your MSP premium). However, some people pay an extra amount because of their yearly income. If your income is above an amount that is determined each year by the Federal government, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration or Railroad Retirement Board, not SFEHACL, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, you can visit www.medicare.gov on the web or call 1-800-Medicare (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Some members are required to pay a Part D late enrollment penalty because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have creditable prescription drug coverage. Creditable means the drug coverage is at least as good as Medicare's standard drug coverage. For these members, the Part D late enrollment penalty is added to the monthly premium. Their premium amount will be the monthly SFEHACL premium plus the amount of their Part D late enrollment penalty.
    - If you are required to pay the Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible.
    - If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the SFEHACL plans. Payment of the penalty is a Medicare requirement.

You must pay the full cost of services that are not covered

With very few exceptions, you are personally responsible to pay for care and services that are not covered by Original Medicare. If you obtain services, items and/or drugs that are not covered, you must pay for them yourself. There are some services and items that may be covered under Original Medicare but are not covered under your SFEHACL Medicare Plans. Other Sections of this document tell about covered services and the rules that apply.

Coinsurance and/or deductible amounts

Original Medicare Part A and B both require that you pay deductible and coinsurance amounts as your share of your medical bills. Your SFEHACL MSP pays all of your Medicare coinsurance and deductible amounts for covered benefits. SFEHACL participation does not affect the payment amount from Original Medicare.

Your SFEHACL MSP does not require you to pay any coinsurance and/or deductible amounts in addition to those imposed by Original Medicare. You may be responsible for payment of some of the Medicare coinsurance and/or deductible amounts for services from out-of-network providers or for SFEHACL noncovered benefits.

You could pay more to see out-of-network providers

Your out-of-pocket costs could be higher if you use out-of-network providers than if you use in-network providers. Original Medicare will pay for covered care that you get from out-of-network providers. SFEHACL participation does not affect the payment amount from Original Medicare.

In most cases, you will pay nothing to see SFEHACL in-network providers because these providers have an agreement with us to accept the Original Medicare amount as payment in full for services provided to you. There are a lot of doctors, hospitals, and other health care providers who are SFEHACL in-network providers. If you do not have a list of our providers for your area and would like to have one, please call Member Services at 1-877-968-3550 ,(TTY call 711) or visit our Website at santafeha.com.

Please keep your plan membership record up to date

Your membership record has information from your enrollment form that includes your name, address, email, and telephone number. SFEHACL uses your membership record to know what services and drugs are covered for you. We use your address to mail all of your notices and your Mail Order Pharmacy prescriptions. We use your telephone number to contact you in case there are situations when we need to talk to you about a hospital or doctor bill or one of your prescriptions. Please contact the RRB if you need to change your name, address, email or phone number.

If you have any of the following informational changes, please contact SFEHACL Member Services:

- Changes in any other health insurance coverage you may have such as liability or your spouse's employer, worker's compensation, or Medicaid
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

PLEASE NOTE: Medicare requires a physical address, not a P.O. Box.

How other insurance works with our plan

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

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

- If you have retiree coverage Medicare pays first
- If your group health plan coverage is based on your or a family member's current employment who pays first depends on your age, the size of the 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 is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, the 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 for perineal-dialysis and 33 hemo-dialysis months after you become eligible for Medicare.

Types of coverage usually pay first:
- No fault insurance including auto insurance.
- Liability including auto insurance.
- Black lung benefits
- Workers' compensation or On-duty Injury 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.
- Medicare never duplicates payment from Veterans Administration Services

If you have additional health insurance, please call Medicare at 1-800-MEDICARE (1-800-633-4227) or SFEHACL Member Services at 1-877-968-3550, (TTY call 711) to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a document with general information about what happens when people with Medicare have additional insurance. It's called Medicare and Other Health Benefits: Your Guide to Who Pays First. You can get a copy by calling Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting their Website at medicare.gov.

What should you do if you have bills from out-of-network providers you think we should pay?

Original Medicare makes payment for your services from out-of-network providers and many other services of SFEHACL in-network providers. Your SFEHACL MSP makes payment secondary to Medicare for the coinsurance and deductible amounts for covered benefits. If an out-of-network provider asks you to pay for the Medicare coinsurance or deductible for covered services, please ask him to bill SFEHACL with Medicare payment information. If you have already paid for the Medicare coinsurance or deductible amount for covered services, we may reimburse you. If you receive a bill for the services, you will need to send the bill along

with your Medicare Summary Notice (MSN) to us for MSP payment. We will pay our share of the bill and let you know what, if anything, you must pay. You will not have to pay the out-of-network provider any more than what is allowed for payment of covered services by Original Medicare.

Section 8 Your rights and responsibilities

Our plan must honor your rights as a member of SFEHACL

Since you have Original Medicare and membership in the SFEHACL Medicare Plans, you have certain rights to help protect you. In the first part of this Section, we explain Medicare rights and protections as a member of SFEHACL. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them from Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect at all times

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

If you need help with communication, such as help from a language interpreter, please call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697 or call the Office for Civil Rights in your area.

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 SFEHACL as well as your claims and any other medical and health information in our possession.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. Your doctor gives you a written notice, called a Notice of Privacy Practice, which tells about these rights.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of SFEHACL through Medicare, we are required to give Medicare your health information including information about your Part D

prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

If you have questions or concerns about privacy of your personal and claims information in possession of SFEHACL, please call SFEHACL Member Services at 1-877-968-3550.

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

Normally, SFEHACL does not have your medical records. You have a right to obtain those from your provider. You have the right to ask your provider to make additions or corrections to your medical records.

You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have a question about how your provider is sharing your health information, you can ask for a full explanation.

Your right to see in-network providers and out-of-network providers and get covered services

As explained in this Evidence of Coverage, you have a choice as to whether or not you see in-network providers, meaning doctors and other health providers who are part of the SFEHACL in-network network. You have the right to choose a SFEHACL in-network provider and to see specialists when care from a specialist is needed. You do not need a referral to see a specialist. Section 2 explains how to use in-network providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed services. Your SFEHACL Prime Medicare Plan 2024 Evidence of Coverage explains your rights under the Medicare Part D prescription drug plan, administered by OptumRx.

Your right to know your treatment choices and participate in decisions about your health care

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

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

- **To know about all of your choices.** This means that you have the right to be told about all the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by Medicare.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say no.** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises

you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from the in-network doctor if you believe they denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Section 10 of this book tells how to ask the plan for a coverage decision.

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

Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can: use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as a State Health Insurance Assistance Program (SHIP). Section 1 of this document tells how to contact a SHIP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you cannot. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it's your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with your State Department of Health.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. Appeals and grievances are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and grievances are discussed in Section 9 and 10. If you make a complaint, we must not treat you unfairly (discriminate against you) because you made a complaint.

Your right to get information about your health care coverage and costs

This document tells you what medical items and services are covered for you under Original Medicare and the SFEHACL HCPP and MSP and what you have to pay. If you need more information, please call Medicare at 1-800-MEDICARE (1-800-633-4227) or SFEHACL Member Services at 1-877-968-3550. TTY call 711. You have the right to an explanation from us about any bills you may get for services not covered by the SFEHACL HCPP and MSP. We must tell you in writing why we will not pay for the service, and how you can make an appeal to ask us to change this decision.

Your right to get information about the SFEHACL Medicare Secondary Plan, and in-network providers

You have the right to get information from us about the SFEHACL Medicare Secondary Plan. This includes information about our financial condition and about SFEHACL in-network health providers. Your Medicare Summary Notice (MSN) and SFEHACL Explanation of Benefits (EOB) explains exactly how payment was made for your benefits. The Medicare program does not allow us to pay doctors in a way that would keep them from giving you the care you need. To get any of this information, call SFEHACL Member Services at 1-877-968-3550, TTY call 711.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at 1-877-968-3550, TTY call 711. You can get free help and information from your State Health Insurance Assistance Program, or SHIP. In addition, the Medicare program has written a document called Your Medicare Rights and Protection. To get a free copy, call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Or you can visit the Medicare Website at medicare.gov to order this document or print it directly from your computer. You can call 24 hours a day, 7 days a week.

What can you do if you think you have been treated unfairly or your rights are not being respected?

- If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.
- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please tell Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or SFEHACL Member Services at 1-877-968-3550, TTY call 711. or, you can call the Office for Civil Rights in your area.
- For any other kind of concern or problem related to your Medicare rights and protections described in this Section, you can call Medicare at 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or SFEHACL Member Services at 1-877-968-3550, TTY call

711. You can also get help from your State Health Insurance Assistance Program, or SHIP.

What are your responsibilities as a member of the SFEHACL Medicare Plans?

Along with the rights you have as a member of SFEHACL, you also have some responsibilities. Your responsibilities include the following:

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Sections 3, 4 and 5 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- If you have any other health insurance coverage, or prescription drug coverage in addition to SFEHACL, you are required to tell us. Please call Member Services to let us know.
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from SFEHACL. This is called coordination of benefits and it involves coordinating the health benefits you get from SFEHACL with any other health benefits available to you. We'll help you with it.
- Tell your doctor and other health care providers that you are enrolled in SFEHACL. Your SFEHACL membership ID card and your red, white and blue Medicare card whenever you get your medical care.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. You must pay your SFEHACL premiums to continue being a member of SFEHACL.
- To be eligible for SFEHACL, you must maintain your eligibility and enrollment in Medicare Part A and Part B. For that reason, plan members must pay a premium for Medicare Part B to remain a SFEHACL member.
- If you get any medical services that are not covered by Medicare and/or SFEHACL, you must pay the full cost.
- If you are required to pay a Part D late enrollment penalty you must pay the penalty to keep your membership in the SFEHACL Medicare Plans.

- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to keep your membership in the SFEHACL Medicare Plans.
- Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call SFEHACL Member Services at 1-877-968-3550, TTY call 711.

Section 9 How to file a complaint

The terms we, us, and SFEHACL are used throughout Sections 9 and 10.

If your problem is about decisions related to benefits, coverage, or payment, then this Section is not for you. Instead, you need to use the process for making a Level 1 appeal. Go to Section 10. This Section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the Member Services you receive. Here are examples of the kinds of problems handled by the complaint process.

Legal Terms

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

Problems that are handled by the complaint process

The complaint process is used for certain types of problems ONLY. This includes problems related to quality of care, waiting times, and the Member Services you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can make a complaint. Call Member Services at 1-877-968-3550, (TTY call 711) if you have a complaint.

- Quality of your medical care
  - Are you unhappy with the quality of the care you have received?
- Respecting your privacy
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- Disrespect, poor Member Services, or other negative behaviors.
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Service has dealt with you?
  - Do you feel you are being encouraged to leave our plan?
- Waiting times
  - Have physicians kept you waiting too long? Have our Member Services or other staff at our plan kept you waiting too long?
  - Examples include waiting too long on the phone.
- Cleanliness
  - Are you unhappy with the cleanliness or condition of a medical office?
- Information that you get from our plan
  - Do you believe we have not given you information that we are required to give?
  - Do you think written information we have given you is hard to understand?
  - Do you believe the materials you received in a different language, or an alternate format were incorrect?

SFEHACL Medicare Secondary Plan complaints

You have the right to file a complaint with SFEHACL about your Medicare Secondary Plan. Complaints involving the MSP follow the SFEHACL processes because benefits under this plan are not subject to the Medicare process. The SFEHACL MSP is not a Medigap plan. The SFEHACL MSP complaint process is explained as follows.

To file a complaint (grievance) about the SFEHACL MSP

Complaints are entirely separate from the appeals process. Complaints do not include disputes about payment amounts or denied payments. A complaint can involve quality of services, quality of benefits, and general complaints. Following are the steps to file a complaint with SFEHACL:

- You may call Member Services at 1-877-968-3550, (TTY call 711) to file your complaint. We prefer that you submit your complaint in writing so that we get all of the facts straight, but you may call Member Services.
- A representative will usually be able to resolve your problem over the telephone at the time of your call.
- You may file a written complaint to SFEHACL stating exactly who, where, what and when the problem occurred. Sometimes it is not possible to resolve the problem if we are not supplied with sufficient facts and information to allow our staff to investigate.
- SFEHACL will acknowledge receipt of your complaint within 30 days, and very often the matter can be resolved within that time. SFEHACL may need more time for a resolution if it is a very complicated matter. In that case SFEHACL will return a written decision regarding the complaint within 60 days of receipt of your written filing.

Mail your SFEHACL complaint to:
SFEHACL Medicare Complaints
551 E San Bernardino Road
Covina, CA 91723

Who may file a complaint?

You or someone you name may file the complaint. The person you name would be your representative. You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the Court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative.

Complaints related to the timeliness of our actions on coverage decisions and appeals

The process of asking for a coverage decision prior to receiving benefits and making an appeal is explained in Section 10 of this book. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint. Here are examples:

- If you have asked us to give you a fast coverage decision or appeal and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Step-by-step process for making a complaint

The following pages give you instructions on how to make complaints.

Step 1 for making complaints

Contact us promptly – either by phone or in writing

- Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know. We can usually resolve any complaint or problem you may have on the telephone.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- Whether you call or write, you should contact Member Services right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you an answer within 24 hours.

Legal Term

- What this Section calls a fast complaint is also called an expedited reconsideration.

Step 2 for making complaints

SFEHACL looks into your complaint and gives you an answer.

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- Sometimes we will ask if we can call you back after we find out more facts about your complaint. Return calls are usually made the same day but can be within 5 business days.
- Most complaints are answered quickly. 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 30 days and 14 more days (44 days total) to answer your complaint.

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

For quality-of-care problems, you may also complain to the QIO
You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO) in your state, or both. If you file with the QIO, we must help them resolve the complaint. See the Important Numbers and Resources Section of this book for help to find the QIO in your state.

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

- You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, addresses, and phone number of the Quality Improvement Organization for your state, look in the Important Phone Numbers and Resources Section of this book. If you make a complaint to this organization, we will work with them to resolve your complaint.
  - You can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.
- You can also tell Medicare about your complaint
  - You can submit a complaint about SFEHACL directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.
  - If you have any other feedback or concerns, or if you feel SFEHACL is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Section 10 Coverage decisions and appeals

How to make appeals in different situations

Who to contact for appeals for Medicare services or payments depends on who processed the claim for your Original Medicare benefits. As a member of the SFEHACL Medicare Plans, you continue to access your benefits through Original Medicare whether or not the provider is in-network with SFEHACL. Being a member of the SFEHACL Medicare Plans includes continued benefit coverage from Original Medicare Part A and Part B.

- SFEHACL HCPP can only perform your Medicare appeal if we processed the original Part B claim from a SFEHACL in-network provider.
- All of your appeals for Medicare Part A benefits are made to the Original Medicare intermediary that processed your claim. The SFEHACL HCPP does not process your Medicare Part A services. However, the SFEHACL MSP does pay secondary to Medicare for your Part A benefits.
- All of your appeals for Medicare Part B claims that were originally processed by Railroad Medicare (Palmetto GBA) must go directly to them and not us. SFEHACL in-network physicians can send your claims either to SFEHACL HCPP or Railroad Medicare (Palmetto GBA) because you are still using your Original Medicare benefits. If a SFEHACL in-network physician sends your claims to Railroad Medicare, we cannot perform a Medicare appeal for you. Your appeal must go to Railroad Medicare.
- Railroad Medicare must pay all of your Medicare Part B claims for services from out-of-network providers that do not participate with SFEHACL. As a SFEHACL Medicare member, you may choose to get care from out-of-network providers anywhere, and at any time using your Original Medicare benefits.
- For more information on how to file an Original Medicare appeal, please refer to your *Medicare and You* handbook.

To file a SFEHACL Medicare Secondary Plan payment appeal

You have the right to appeal payment amounts or denied payments by your SFEHACL Medicare Secondary Plan. The steps that are available to you are as follows:

- You, your representative, or an in-network provider must file your appeal in writing within 180 days of the time the claim for Medicare secondary payment was processed by SFEHACL MSP or call SFEHACL Member Services at 1-877-968-3550. Additional information that may aid in reconsidering the payment must be submitted at the time of your appeal. SFEHACL must return a written decision to you within 60 days from the date of receipt of your written appeal.
- Should we uphold our initial payment decision and you do not agree, you can next appeal to the President of SFEHACL within 60 days of that decision. The President has 60 days in which to make a decision on this appeal.
- If the President upholds the initial payment decision and you still do not agree, you may make a final appeal to the SFEHACL Board of Trustees. Instructions on how to appeal to the Board of Trustees will be supplied to you in the President's response.

Mail your SFEHACL MSP payment appeal to:
SFEHACL Appeals

551 E San Bernardino Road
Covina, CA 91723

How to file a complaint about services or payment in each of the following situations:

- Part 1. Requests for Medicare Part B payments or medical care that would normally be processed/paid through the SFEHACL HCPP.
- Part 2. Complaints if you think you are being asked to leave the hospital too soon.
- Part 3. Complaints if you think coverage for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.

PART 1: Medicare Part B medical services that are processed or paid through the SFEHACL HCPP

This part explains what you can do if you have problems getting the Part B medical care or service you request, or payment (including the amount you paid) for Part B medical care or a service you already received that would normally be processed/paid through the SFEHACL HCPP. If you have problems getting the Part B medical care or services you need, or payment for a Part B service you already received, you must request a coverage decision from SFEHACL.

Coverage decisions

The coverage decision is the starting point for dealing with requests you may have about covering a Part B medical care or service that you need or paying for a Part B medical service that you already received. Coverage decisions are called organization determinations. With this decision, we tell you whether Medicare Part B will provide the medical care or service you are requesting through the SFEHACL HCPP or pay for the Part B medical care or service you already received.

The following are examples of requests for coverage decisions:

- If you are told that Medicare does not cover the medical treatment your doctor or other medical provider wants to give, and you believe that Medicare covers this treatment.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe Medicare should cover, but we have refused to pay for this care because we say it is not covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we will not review the request. Examples of when a request will be dismissed

include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn, If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed an how to ask for a review of the dismissal.
We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Who may ask for a coverage decision?
For medical care, a doctor can make a request for you. Your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

You can ask for a coverage decision yourself, or you can name someone to do it for you. This person you name would be your authorized 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 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 authorized representative. This form is available on Medicare's website at cms.hhs.gov/cmsforms/downloads/cms1696.pdf

This statement must be sent to us at SFEHACL, 551 E San Bernardino Road Covina, CA 91723. You can call us at 1-877-968-3550, TTY use the national number 711, to learn how to name your authorized representative. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a standard decision
To ask for a standard decision about Part B medical care or payment for care that SFEHACL HCPP would normally process/pay, you or your authorized representative should mail a request in writing to the following address: SFEHACL, 551 E San Bernardino Road Covina, CA 91723. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

Asking for a fast decision
You may ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. Fast decisions apply only to requests for benefits that you have not yet received and to those medical services that SFEHACL HCPP would normally process/pay. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.

You, your doctor, or your authorized representative can ask for a fast decision (rather than a standard decision) about medical care by calling us at 1-877-968-3550 for TTY, call the national number 711). Or, you can deliver a written request to SFEHACL at 551 E San Bernardino Road Covina, CA 91723. You can send a written request to SFEHACL, 551 E San Bernardino Road Covina, CA 91723, or fax it to (626) 967-3161. Be sure to ask for a fast or 72-hour decision. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

- If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.
- If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast-initial decision, we will send you a letter informing you that if you get a doctor's support for a fast decision, we will automatically give you a fast decision. The letter will also tell you how to file a grievance if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a fast grievance. If we deny your request for a fast-initial decision, we will give you a standard decision.

What happens if we decide against you?
If the decision is not one that would be made by SFEHACL HCPP, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

If we decide against you, we will send you a written decision explaining why we denied your request. If a coverage decision does not give you all that you requested, you have the right to appeal the decision. See Appeal Level 1.

Appeal Level 1: Appeal to SFEHACL HCPP for our denial of a Part B medical service or payment

Legal Term

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

You may ask us to review our coverage decision, even if only part of that decision is not what your requested. An appeal to SFEHACL HCPP about Part B medical care coverage decision is also called reconsideration. Please call us at 1-877-968-3550 if you need help in filing your appeal. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

Who may file your appeal of the coverage decision?
If you are appealing a coverage decision about Part B medical care or services that SFEHACL HCPP would normally process/pay, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under Who may ask for a coverage decision. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

How soon must you file your appeal?
You must file your appeal within 60 calendar days from the date included on the notice of our coverage decision. We may give you more time if you have a good reason for missing the deadline. If the decision is not one that would be made by SFEHACL HCPP, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

How to file your appeal

- Asking for a standard appeal
  - To ask for a standard appeal about a Part B medical care or service that has been processed/paid by the SFEHACL HCPP, send a signed, written appeal request to: SFEHACL Appeals, 551 E San Bernardino Road Covina, CA 91723. Or you may call Member Services at 1-877-968-3550, Monday through Friday from 7:30 AM to 4:00 PM, Pacific Time. TTY call 711.
- Asking for a fast appeal
  - If you are appealing a decision we made about giving you a Part B SFEHACL HCPP medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage decision. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed on the cover of this book.
  - Be sure to ask for a fast or expedited review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a fast grievance. You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 9). If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal
We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information. If the decision is not one that would be made by SFEHACL HCPP, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

- If the decision is one that would be made by SFEHACL, you can give us your additional information in any of the following ways:
- In writing, to SFEHACL Appeals, 551 E San Bernardino Road Covina, CA 91723.
- By fax, at (626) 967-3161
- By telephone, if it is a fast appeal, at 1-877-968-3550.

- In person, at SFEHACL, 551 E San Bernardino Road Covina, CA 91723.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at the above address. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

How soon must we decide on your appeal?
How quickly the decision is made on your appeal depends on the type of appeal. Remember, SFEHACL can only perform an appeal on a Medicare Part B claim that was processed by us. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

- For a decision about SFEHACL HCPP payment for care or services you already received.
  - After your appeal is received, a decision must be made within 60 days. If the decision is not made within 60 days, your appeal automatically goes to Appeal Level 2.
- For a standard decision about SFEHACL HCPP medical care or services you have not received.
  - Remember, this must be Part B medical care or services you want to receive from a SFEHACL HCPP in-network physician and one that SFEHACL HCPP would normally process/pay. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227. After we receive your appeal, we have up to 30 days to decide, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.
- For a fast decision about Part B medical care or services you have not received that SFEHACL HCPP would normally process/pay.
  - Remember, this must be medical care you want to receive from a SFEHACL in-network physician. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227. After we receive your appeal, we have up to 72 hours to make a decision but will make it sooner if your health requires. However, if you request it, or if there is some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go Appeal Level 2.

What happens next if we decide completely in your favor?

- For a decision about payment for Part B SFEHACL HCPP medical care or services you already received.
  - We must pay within 60 days of the day we received your appeal request. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.
- For a standard decision about Part B SFEHACL HCPP medical care or services you have not received.

    - We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal request. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision. If the decision is not one that would be made by SFEHACL HCPP, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.
- For a fast decision about Part B SFEHACL HCPP medical care or services you have not received.
- We must authorize or provide the requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your care at the time we make our decision. If the decision is not one that would be made by SFEHACL, we will direct you to the proper resource or you can call Medicare at 1-800-633-4227.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program, reviews it. The IRE has no connection to SFEHACL HCPP. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part B SFEHACL HCPP medical care or services, or payment for Part B SFEHACL HCPP medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as SFEHACL had at Appeal Level 1.

If the IRE decides completely in your favor

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision about payment for Part B SFEHACL HCPP medical care or services you already received.
    - We must pay within 30 days after we receive notice reversing our decision.
- For a standard decision about Part B SFEHACL HCPP medical care or services you have not yet received.
    - We must authorize your requested Part B SFEHACL HCPP medical care or service within 72 hours or provide it to you within 14 days after we receive notice reversing our decision.
    - For a fast decision about Part B SFEHACL HCPP medical care or services.
    - We must authorize or provide your requested Part B medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part B SFEHACL HCPP medical care that you asked for meets the minimum requirement provided in the IRE's decision.

During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal
The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part B SFEHACL HCPP medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?
The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor
See the Section *Favorable Decisions by the ALJ, MAC, or a Federal Court Judge* below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)
If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal
The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?
The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:
See the Section Favorable Decisions by the ALJ, MAC, or a Federal Court Judge below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request

How soon will the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

SFEHACL HCPP or Original Medicare must pay for, authorize, or provide the service you have asked for within 60 days from the date the decision notice is received. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This Section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision about SFEHACL HCPP Part B medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2: Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by Original Medicare that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the Important Message from Medicare. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.

- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization
If you think that you are being discharged too soon, ask to be given a notice called the Notice of Discharge & Medicare Appeal Rights. This notice will tell you:

- Why you are being discharged
- The date that Original Medicare will stop covering your hospital stay (stop paying their share of your hospital costs)
- What you can do if you think you are being discharged too soon
- Who to contact for help.

You (or your representative) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital, it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if you act quickly, you can ask an outside agency called the Quality Improvement Organization (QIO) to review whether your discharge is medically appropriate.

What is the Quality Improvement Organization (QIO)?
The QIO is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. They are not part of Medicare, SFEHACL, or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in your state QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO in your state.

Getting a QIO review of your hospital discharge
If you want to have your discharge reviewed, you must act quickly to contact the QIO. The Notice of Discharge & Medicare Appeal Rights gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a fast review of whether you are ready to leave the hospital. This fast review is also called an immediate review or an expedited review.
- You must be sure that you have made your request to the QIO no later than noon on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

What happens if the QIO decides in your favor?
If the QIO agrees with you, then Original Medicare will continue to cover your hospital stay for as long as medically necessary.

What happens if the QIO denies your request?
If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision.

What if you do not ask the QIO for a review by the deadline?
You still have another option: asking Original Medicare for a fast appeal of your discharge.

If you do not ask the QIO for a fast appeal of your discharge by the deadline, you can ask Original Medicare for a fast appeal of your discharge. How to ask them for a fast appeal is covered in Part 1 of this Section.

If you ask Original Medicare for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision Original Medicare makes.

- If Medicare decides, based on the fast appeal, that you need to stay in the hospital, they will continue to cover your hospital care for as long as medically necessary.
- If Medicare decides that you should not have stayed in the hospital beyond your discharge date, they will not cover any hospital care you received after the discharge date unless the independent review organization overturns their decision.
- If Original Medicare denies a continued hospital stay, your SFEHACL MSP will not pay for any portion of the continued stay.

PART 3: Complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services are ending too soon

When you are a patient in a SNF, Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Original Medicare that is necessary to diagnose and treat your illness or injury. The day they end your SNF, HHA or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay
If Original Medicare decides to end their coverage for your SNF, HHA, or CORF services, you will get a written notice either from them or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end, it only means that you received the notice.

How to get a review of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of Original Medicare's termination of your coverage. As will be explained in the notice you get from the provider, you can ask the Quality Improvement Organization (QIO) to do an independent review of whether it is medically appropriate to end your coverage.

How soon do you have to ask the QIO to review your coverage?
If you want to have the termination of your coverage appealed, you must quickly contact the QIO. The written notice you got from Original Medicare or your provider gives the name and telephone number of the QIO in your state and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request no later than noon of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your coverage ends.

What will happen during the review?
The QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that Medicare has given to the QIO. You and the QIO will each get a copy of their explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate to terminate your coverage on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?
If the QIO agrees with you, then Original Medicare will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request?
If the QIO decides that Original Medicare's decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from Medicare or your provider. Neither Original Medicare nor SFEHACL MSP will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review by the deadline?
You have the option of asking Original Medicare for a fast appeal of your discharge.

If you do not ask the QIO for a fast appeal by the deadline, you can ask Original Medicare for a fast appeal. How to ask them for a fast appeal is covered in Part 1 of this Section.

- If you ask Original Medicare for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision Original Medicare makes.

- If Original Medicare decides, based on fast appeal, that you need to continue to get your services covered, then they will continue to cover your care for as long as medically necessary.
- If Original Medicare decides that you should not have continued getting coverage for your care, they will not cover any care you received after the termination date.
- Remember, if Original Medicare decides not to continue coverage, then your SFEHACL MSP will not make payment either.

Section 11 Eligibility, enrollment and leaving the SFEHACL Medicare Plan

What is disenrollment?

Remember, if you choose to leave the SFEHACL Medicare Plans, they may not be offered to you again.

Disenrollment from the SFEHACL Medicare Plans means leaving (ending your membership) in the SFEHACL HCPP & Medicare Secondary Plan (MSP) and the SFEHACL Prime Medicare Part D prescription program. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

- You might leave the SFEHACL Medicare Plans because you have decided that you want to leave. You can do this at any time for any reason. However, we explain in this Section more about when you may leave, what your other choices are for receiving Medicare services, and how you can make changes.
- There are also a few situations where you do not choose to leave, but we are required to end your membership. For example, you would have to leave the SFEHACL Medicare Plans if we leave the Medicare program. We are not allowed to ask you to leave the plan because of your health.
- You can find information in the Medicare and You handbook sent to you in the fall. Or you can contact Medicare at 1-800-Medicare (1-800-633-4227) 24 hours a day 7 day a week. TTY users should call 1-877-486-2048.

Eligibility for the SFEHACL Medicare Plans

SFEHACL Medicare Plan membership is restricted to certain Railroad retirees and their spouse and is not offered to the public. SFEHACL does not exclude or limit membership based on your health condition. When you retire from active railroad employment, you must enroll in Medicare Parts A and B at the time of first eligibility and convert your SFEHACL active or early retiree coverage to the SFEHACL Medicare Plans. Continued eligibility for all other SFEHACL plans terminates at the time of Medicare eligibility.

The SFEHACL MSP pays supplemental benefits to Original Medicare. When a member refuses membership in the SFEHACL Medicare Plans at the time of Medicare eligibility and enrollment, all SFEHACL plan eligibility ends, and SFEHACL plans may not be offered again.

The following stipulations apply to eligibility for membership in the SFEHACL Medicare Plans:

- Premiums for membership are paid monthly or quarterly (three months at-a-time) to SFEHACL. Premiums must be paid on time. The SFEHACL Board of Trustees determines the amount of premiums.
- Failure to enroll in Medicare Part A and B at the time of first eligibility will terminate eligibility for all SFEHACL plans unless you are still actively employed by the railroad or have full coverage under your spouse employment.
- Medicare members are not permitted to duplicate benefits that are available from Medicare with benefits that are provided under any other SFEHACL, or any other plan.
- A Medicare spouse (of a retiree who is a member of SFEHACL Medicare Plans) is eligible for the SFEHACL Medicare Plans when that spouse is entitled to Medicare Part A and enrolled in Part B. The SFEHACL Medicare Plan benefits are the same for the

Medicare spouse as those available to all Medicare plan members. Eligibility for SFEHACL membership for a Medicare spouse terminates upon divorce.

- A Medicare-eligible spouse of an active working SFEHACL member continues to have health care coverage under the Railroad National Health and Welfare Dependent Plan. They are not eligible for the SFEHACL Medicare Plans until the active working spouse becomes a retiree.
- A Medicare widow(er) is eligible for the SFEHACL Medicare Plans when they become entitled to Medicare Part A and enrolled in Part B if the deceased spouse was eligible for SFEHACL membership at the time of death. Eligibility for SFEHACL membership for a Medicare widow(er) terminates upon remarriage.

Enrollment in the SFEHACL Medicare Plans

SFEHACL members must enroll in Medicare at the time of first eligibility and convert to our Medicare Plans if not still actively working. Eligibility for all other SFEHACL plans terminates at the time of Medicare eligibility. It is your responsibility to inform SFEHACL when you become eligible for Medicare benefits so that you do not lose your rights to SFEHACL Medicare Plan membership.

SFEHACL mails a notice and application form to you so that you can join the SFEHACL Medicare Plans when you become eligible. You must return the completed and signed application form to us with proof of your Medicare enrollment (a copy of your Medicare card Part A & B). We submit the information you have given us to Medicare for approval. Your membership must be approved by them, and they authorize us to make the Medicare HCPP Part B payment for your services. At the same time, your secondary coverage starts under the SFEHACL MSP. CMS approves your Part D eligibility and enrollment separately so that effective date may be different. Once CMS approves your Part D enrollment, you begin receiving your Medicare Part D prescription benefits through the OptumRx Part D Plan.

If you refuse membership in the SFEHACL Medicare Plans or fail to inform SFEHACL of Medicare eligibility at the time you first become eligible for Medicare, all other SFEHACL plan eligibility ends, and SFEHACL plans may not be offered again.

Effective date of enrollment in the SFEHACL Medicare Plans

The effective date of your enrollment in the SFEHACL Medicare Plans is the date CMS approves you and it is indicated on the enrollment confirmation letter we send you after we receive your completed application. Coverage will begin on the first day of the month in which you become eligible for Medicare, or on the first day of the month following receipt of your application, whichever date is later. You will also receive information regarding premiums, your new SFEHACL Health Insurance ID Card and current Medicare publications.

In most cases, you may continue to obtain services from the same SFEHACL in-network providers that you have used under other SFEHACL plans. If you need a new list of SFEHACL Medicare in-network providers for your area, or if you are unsure of your provider's participation, you may look on the SFEHACL website at santafeha.com or call Member Services at 1-877-968-3550 (TTY call 711) and order a customized area and/or specialty specific

directory. You may still obtain services from out-of-network providers under Original Medicare, but you may be responsible for payment of a portion not paid by Medicare.

When can you end your membership in the SFEHACL Medicare Plans?
Remember, if you leave the SFEHACL Medicare Plans, they may not be offered to you again.

You may end your membership in the SFEHACL Medicare Plans any time during the year and just have Original Medicare. To end your membership, you must make a request in writing to us. Your membership will end on the last day of the month in which we receive your request.

- If you disenroll from your SFEHACL Medicare Part D Plan and go without creditable prescription drug coverage, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. Credible coverage means the coverage is expected to pay on average at least as much as Medicare's standard prescription drug coverage.

Your choices and how to make changes if you leave the SFEHACL Medicare Plans between October 15th and December 7th
As a member of the SFEHACL Medicare Plans, you already have Original Medicare Part A and B and are receiving your Medicare benefits through them. If you want to leave the SFEHACL Medicare Plans, so that you just have Original Medicare, you must tell us in writing.

If you leave the SFEHACL Medicare Plans between October 15th and December 7th during the annual election period (AEP), you have a number of choices for how you receive Medicare after you leave. If they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- Another Medicare health plan. If you enroll in a different Medicare health plan, you will automatically be disenrolled from the SFEHACL Medicare plans when your new plan's coverage begins.
- Original Medicare with a separate prescription drug plan. Enroll in a new Medicare drug plan and you will automatically be disenrolled from all SFEHACL Medicare Plans. Your coverage in Original Medicare continues.
- Original Medicare without a separate Medicare prescription drug plan. Send us a written request to disenroll. You will be disenrolled from the SFEHACL Medicare Plans and have Original Medicare only with no prescription drug plan.
- Medicare Prescription Drug Plans (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- For more information about your choices, please refer to your *Medicare and You* handbook you received in the fall. You may also call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov.

Remember, if you leave the SFEHACL Medicare Plans, they may not be offered to you again.

Until your membership ends, you are still a member of the SFEHACL Medicare Plans

If you leave SFEHACL, it may take time before your membership ends and your new Medicare coverage goes into effect. As long as your coverage continues under SFEHACL please:

- Continue to use both your SFEHACL ID card and your Medicare ID card until your membership ends.
- Continue to use in-network providers for your medical services and SFEHACL will continue coverage of your Medicare coinsurance.
- Remember, if you use out-of-network providers for your medical services, they are covered under Original Medicare.

Under certain conditions SFEHACL can end your membership and make you leave the plan

We cannot ask you to leave the plan because of your health. No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave SFEHACL because of your health, you should call 1-800-MEDICARE 1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line.

SFEHACL must end your membership if any of the following happen:

- If you do not stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance, you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you enroll in our plan and that information affects your eligibility.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of SFEHACL. We cannot make you leave SFEHACL for this reason unless we get permission first from CMS, the government agency that runs Medicare.
- If you let someone else use your SFEHACL membership card to get medical care or prescription drugs. If we ask you to leave SFEHACL for this reason, Medicare may have your case investigated by the Inspector General, and that may result in criminal prosecution.
- If you do not pay the plan premiums, you are disenrolled from all SFEHACL Medicare plans after the second month of non-payment. During this grace period, you can pay the plan premiums before you are required to leave SFEHACL.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our Part D Plan and that will automatically disenroll you from the SFEHACL HCPP and Medicare Secondary plans.
- A member of a Medicare health plan must be a U.S. citizen or lawfully present in the U.S. Medicare will notify SFEHACL if you are not eligible to remain a member on this basis.

Section 12 Legal notices

Notice about governing law

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

Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on race, ethnicity, nationality, origin, color, gender, mental or physical disability, religion, sex, health status, ethnicity, age, national origin, medical history, genetic information, evidence of insurability or geographic location. All organizations that provide Medicare health plans, like SFEHACL, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive Federal funding, and any other laws and rules that apply for any other reason.

Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals. Section 1557 has been in effect since its enactment in 2010 and the HHS Office for Civil Rights has been enforcing the provision since it was enacted.

If you believe that we have failed to provide these services or discriminated in another way based on race, color, national origin, age, gender, disability, or sex, you may send a complaint to:

SFEHACL Civil Rights Coordinator
551 E San Bernardino Rd, Covina, CA 91723
Phone: 1-877-968-3550, TTY711
Fax: 1-626-967-3161

If you need help filing a complaint or need this information in another format like large print, please call our Member Services at 1-877-968-3550, TTY711. A representative will be able to assist you. This call is free.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone, or by mail:
Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at: hhs.gov/ocr/office/file/index/html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TTY/TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue,
SW Room 509F, HI-IH Building
Washington, D.C. 20211

Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare health and prescription drug claims payments for which neither SFEHACL nor Medicare is the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, SFEHACL, as a Medicare HCPP, Secondary Plan and prescription drug plan sponsor, 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.

Information required by the Employee Retirement Income Security Act of 1974 (ERISA)

As a Member in the SFEHACL, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the SFEHACL office all documents governing the Plan, including a copy of the latest annual report filed by our Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of documents governing the operation of the Plan copies of the latest annual report and updated summary plan description upon written request to our Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duty upon the people who are responsible for the operation of the employee benefit plan. The people who operate SFEHACL are called Fiduciaries of the Plan. They have a duty to do so prudently and in the interest of you and other Plan participants and members.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of Plan documents or the latest annual report and do not receive them within thirty days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. To ensure your request was not lost in the mail, you should call the Plan Administrator first. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees: for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20211, telephone 866-444-3272 (toll free). You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications line of the Employee Benefits Security Administration at 202-693-8673 (this is a toll line).

Name of Plan	Santa Fe Employes Hospital Association-Coast Lines (the "Plan")
Plan Sponsor	Santa Fe Employes Hospital Association – Coast Lines
Plan Identification Numbers	Employee Identification Number (EIN): 95-1191130 CMS HCPP Plan Number (PN): H6053; CMS OptumRx PDP Plan Number (PN) S8841;
Plan Administrator	Santa Fe Employes Hospital Association-Coast Lines 551 East San Bernardino Road Covina, CA. 91723 Telephone: 877-968-3550 Fax: 626-967-3161
Type of Plan	Health Care Benefit Plan; Medicare HCPP; Medicare Prescription Drug Plan, administered by Optum Rx.
Trustee	Wells Fargo Bank, NA 5 Park Plaza, 20th Floor Irvine CA 92614
Current Board of Trustees of Plan	Larry D. Philippi – Chairman David M. Bocanegra – Vice-Chairman Stephen T. Dawson – Secretary/Treasurer Greg Luiz – Member Daniel Lee O'Connell – Member Tommy G. Pate – Member
Operating Trustees	Larry D. Philippi, Chairman Stephen T. Dawson – Secretary/Treasurer
Agent for Service of Legal Process	Service of Legal Process may be made upon the Plan Administrator, or any Trustee listed above.
Type of Administration of Health Care Benefits Provided by the Plan & Plan Year	Trustees and Self-Administered. The Plan is administered directly by the Plan Administrator. The Plan's healthcare benefits are funded directly by the Plan and are not insured by an outside entity. Each Plan Year ends each year on December 31.

Section 13 Definitions of important words

This Section gives a definition or explanation of some of the words used in this book.

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

ANNUAL ENROLLMENT PERIOD. The Annual Enrollment Period (AEP) is from October 15 until December 7. It is a set time each fall when Medicare members can change their health or drug plans.

APPEAL. An appeal is a special type of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item/service you think you should be able to receive. Section 10 explains about appeals, including the process involved in making an appeal.

EVIDENCE OF COVERAGE. This document which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of the SFEHACL Medicare Plans.

BENEFIT PERIOD. The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you go into a hospital or SNF. A benefit period ends when you haven't received any inpatient hospital care or SNF care for 60 days in a row. If you go into a hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. (The type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital.)

BOARD OF TRUSTEES. The Governing Board of Trustees of Santa Fe Employes Hospital Association-Coast Lines.

CARE COORDINATOR. A Licensed Registered Nurse employed by SFEHACL to help members of all plans coordinate medical care in complicated treatment situations.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS). The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

COINSURANCE. The amount that Medicare does not pay for approved benefits. Coinsurance is usually 20%, but your SFEHACL MSP pays this amount for you for most services when you obtain those services from in-network providers.

COMPLAINT. The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to

quality of care, waiting times and the Member Services you receive. See also "Grievances" in this list of definitions.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF). A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

COST-SHARING. Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; SFEHACL pays your deductible amounts (2) any fixed co-payment amounts that a plan may require be paid when specific services are received; or (3) any coinsurance amount that must be paid as a percentage of the total amount paid for a service. SFEHACL pays both deductibles and coinsurance for most Medicare covered services.

COVERED SERVICES. The general term we use in this document to mean all of the health care services and supplies that are covered by Original Medicare and/or SFEHACL.

CRITICAL ACCESS HOSPITAL. A small facility that provides outpatient services, as well as inpatient services on a limited basis to people in rural areas.

MEMBER SERVICES. A department within SFEHACL that is responsible for answering your questions about your membership, benefits, claims, grievances, and appeals. See the cover of this book and Section 1 for information about how to contact Member Services.

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

DEDUCTIBLE. The amount under Original Medicare that you must pay for the health care services you receive. SFEHACL pays your Original Medicare Part A, Part B, and Part D annual deductible amounts.

DEPOT DRUG MAIL ORDER PHARMACY. The pharmacy mail service owned and operated by Iron Road Healthcare for use by members to obtain maintenance prescriptions.

DISENROLL OR DISENROLLMENT. The process of ending your membership in the SFEHACL Medicare Plans. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

DURABLE MEDICAL EQUIPMENT (DME). DME is certain medical equipment that is ordered by your doctor for medical reasons. Examples are oxygen, walkers, wheelchairs or hospital beds.

ELIGIBILITY FOR SFEHACL MEDICARE PLANS. The SFEHACL Board of Trustees maintains the right to declare eligibility for membership in SFEHACL. Generally, former employees and retirees of the Santa Fe Railroad (SFRR) or its subsidiaries are considered to be eligible for the SFEHACL Medicare Plans. Some are eligible immediately upon Medicare enrollment and others only at Medicare open enrollments. See Section 11.

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

EMERGENCY CARE. Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

EXTRA HELP. A Medicare program to help people with limited income and resources pay Medicare Part D prescription drug program costs, such as premiums, deductibles and coinsurance.

EVIDENCE OF COVERAGE (EOC) AND DISCLOSURE INFORMATION. This document, along with your enrollment form (and any other attachments or riders),which explains your coverage, what we must do, your rights, and what you have to do as a member of the SFEHACL Medicare Plans.

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

HEALTH CARE PREPAYMENT PLAN (HCPP). A health care plan authorized through a Federal contract to perform certain Medicare Part B official functions on behalf of members. SFEHACL is contracted with CMS as an HCPP. This contract authorizes SFEHACL to pay Original Medicare Part B claims to in-network physicians for office visits and related office services, consultations, hospital visits and surgical procedures.

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

HOME HEALTH CARE. This is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the

Benefits Chart in Section 4 under the heading Home Health Care. If you need home health care services, Original Medicare will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

HOSPICE CARE. Hospice is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov/Publications and under Search, type in Medicare Hospice Benefits. Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048).

HOSPITAL INPATIENT STAY. A hospital stays 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."

INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA). If your income is above a certain limit, you will pay for an income-related monthly adjustment amount in addition to your plan premium. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

INITIAL ENROLLMENT PERIOD. When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you are eligible for Part B 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.

INPATIENT HOSPITAL CARE. To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

LOW INCOME SUBSIDY (LIS). See "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. Medicaid programs vary from state to state, 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. Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan (like SFEHACL), or a Medicare Advantage Plan.

MEDICARE ADVANTAGE PLAN (MA). Sometimes called Medicare Part C. SFEHACL is NOT an MA plan. These are plans offered by private companies that are contracted with Medicare to provide all Medicare Part A and Part B benefits. A MA plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan or a Medicare Medical Savings Account (MSA) plan. When enrolled in an MA plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, MA plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage (MAPD's). Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area.

MEDICARE HEALTH COST PLAN. A Medicare Health Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract. Medicare has stated that SFEHACL HCPP is a Health Cost Plan, however our contract is under Section 1833 of the Act and we are NOT an HMO or a CMP.

MEDICARE-COVERED SERVICES. Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

MEDICARE 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.

MEDICARE SPOUSE. A Medicare spouse (of a retired Medicare employee who is a member of SFEHACL) is eligible for the SFEHACL Medicare Plans when the spouse is entitled to Medicare Part A and enrolled in Medicare Part B. Benefits are the same for the Medicare spouse as those available to all eligible Medicare members. Spouse eligibility for SFEHACL Medicare Plans membership terminates upon divorce.

MEDICARE WIDOW(ER). A Medicare widow(er) is eligible for the SFEHACL Medicare Plans when they first become entitled to Medicare Part A and enrolled in Medicare Part B if the deceased spouse was eligible for SFEHACL membership at the time of death. Eligibility for the SFEHACL Medicare Plans terminates upon remarriage.

MEDIGAP PLAN - (MEDICARE SUPPLEMENT INSURANCE). Medicare supplemental insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. SFEHACL MSP is not a Medigap plan because our membership is limited to UPRR Medicare retirees and spouses.

MEMBER (MEMBER OF SFEHACL OR PLAN MEMBER). A person with Medicare who is eligible to get covered services, who has enrolled in SFEHACL, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services (CMS).

NETWORK PROVIDER OR PARTICIPATING PROVIDER. Provider is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them network providers or in-network providers when they have an agreement with SFEHACL to accept our payment as payment in full. SFEHACL pays network providers based on Medicare allowed amounts.

NONPARTICIPATING PROVIDER OR OUT-OF-NETWORK FACILITY. A provider or facility that we have not arranged with to coordinate or provide covered services to members of the SFEHACL Medicare Plans. Also known as out-of-network or non-plan providers, they are providers that are not contracted with SFEHACL to deliver covered services to you.

ORGANIZATION DETERMINATIONS. (Coverage Decisions) Medicare or the SFEHACL plan has made an organization decision when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered benefits. Organization determinations are called coverage decisions in the book. All of the coverage decisions made by SFEHACL are based on Original Medicare benefit coverage.

ORIGINAL MEDICARE. Original Medicare is offered by the government and not a private health plan like an MA plan or prescription drug plan. SFEHACL members get their Medicare Part A and Part B benefits from Original Medicare. Under Original Medicare, services are covered by paying amounts established by Congress to doctors, hospitals, and other health care providers. You can see any doctor, hospital or other health care provider that accepts Medicare. Medicare reduces payments for non-Medicare providers. You must pay the deductible and coinsurance. SFEHACL MSP pays your deductible and coinsurance for most services when you use SFEHACL in-network providers and we reduce our payment for out-of-network providers. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

OUT-OF-NETWORK PROVIDER OR OUT-OF-NETWORK FACILITY. A provider or facility with no SFEHACL participation agreement. The provider may or may not participate with Medicare. SFEHACL members may obtain benefits from Out-of-Network providers if they participate with Medicare.

OUT-OF-POCKET COSTS. See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of the services received is also referred to as the member’s “out-of-pocket.”

PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR (GBA). Palmetto GBA may process your Medicare Part B claims that are not sent to SFEHACL HCPP. Palmetto GBA is the Railroad Medicare Part B carrier. Palmetto GBA would process all of your Medicare claims from out-of-network providers, but whether or not the provider is in-network with SFEHACL, Palmetto GBA is still able to process your claims. You can call Palmetto GBA at 1-800-833-4455, or write to Palmetto GBA, PO Box 10066, Augusta, GA 30999-0001.

PART C. See Medicare Advantage (MA) Plan.

PART D. The Voluntary Prescription Drug Benefit Program. SFEHACL Prime Medicare Part D Prescription Drug Plan (PDP), administered by OptumRx.

PART D DRUGS. Drugs that can be covered under Part D. SFEHACL includes most Part D drugs in our formulary. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Refer to your Part D Evidence of Coverage, provided by OptumRx.

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 the plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your higher out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

PREMIUM. The monthly payment you make for your SFEHACL Medicare Plans. You must also pay Medicare a monthly premium for Medicare Part B. Some people have a Medicare Part A premium.

PROVIDER. See Network Provider or Non-Participating Provider.

PROSTHETICS AND ORTHOTICS. These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

PRIMARY CARE PHYSICIAN (PCP). A health care professional who is trained to give you basic care. Your PCP is responsible for providing or referring you for covered services while you are their patient. SFEHACL does not require that you have a PCP, but strongly encourages you to have one.

QUALITY IMPROVEMENT ORGANIZATION (QIO). Groups of practicing doctors and other health care experts who are paid by the Federal government to check and improve the care given

to Medicare patients. See Section 1 for information about how to contact the QIO in your state and Section 9 for information about making complaints to the QIO.

RAILROAD MEDICARE. Medicare Part A and B program for retirees of the railroad. Most SFEHACL Medicare members receive their Medicare benefits through the Railroad Retirement Board. You can call your local Railroad Retirement Board office or1-877-772-5772 (calls to this number are free). The TTY number is 1-312-751-4701. You can also visit their Website at rrb.gov/

REHABILITATION SERVICES. These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

SERVICE AREA. The SFEHACL service area is national. That means that SFEHACL has in-network providers in all states of America including Alaska and Hawaii. Our Service area is the geographic area approved by the Centers for Medicare and Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

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

SPECIAL ENROLLMENT PERIOD (SEP). A set time when members can change their health or drug plans or just use Original Medicare. Situations in which you may be eligible for a SEP include: if you are getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

SUPPLEMENTAL SECURITY INCOME (SSI). A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

SANTA FE EMPLOYES HOSPITAL ASSOCIATION-COAST LINES (SFEHACL). A voluntary employee benefit administration program that administers health care benefits to certain employees of SFRR and their subsidiaries and affiliated companies, SFRR retirees, SFRR pensioners and their qualified spouse, and dependents of SFRR employees.

SFEHACL MEDICARE SECONDARY PLAN (MSP). A Medicare secondary insurance plan for qualified SFEHACL Medicare retirees and their qualified spouse. Members must be entitled to Medicare Part A and enrolled in Part B. The SFEHACL MSP pays the Medicare Part A and B annual deductible amounts and coinsurance for allowed charges for covered benefits. All Medicare members who elect coverage under the SFEHACL Medicare Plans are also automatically enrolled in the SFEHACL HCPP and the SFEHACL Prime Medicare Plan (Part D) administered by OptumRx.

URGENTLY NEEDED CARE. Urgently needed services is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers, or by out of network providers when an in-network provider is temporarily unavailable or inaccessible.

Multi-language interpreter services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call 1-877-968-3550 our Member Services representatives are available Monday through Friday, from 7:30am to 4:00 pm, Pacific Time. TTY/TDD users call the national number 711.

This letter is also available in other formats like large print. To request the document in another format, please call 1-877-968-3550, TTY/TDD 711.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話 號碼

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

ةيبرعلا (Arabic)، ىلع دوجوملا يناجملا فتاهلا مقر ىلع لاصتلاا ءاجرلا .كل ةحاتم ةيناجملا ةيوغللا ةدعاسملا تامدخ نإف ثدحتت تنك اذإ :هيبنت
.ةيوضعلا فرعم

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION: Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d’identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić
pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語(Japanese)を話される場合、無料の言語支援サービスをご利用いただけます。健康保険 証に記載されているフリーダイヤルにお電話ください。

تراک یور هک یناگیار نفلت هرامش اب افطل .دشاب یم امش رایتخا رد ناگیار روط هب ینابز دادما تامدخ ،تسا (Farsi)
هجوت :یسراف امش نابز رگا
.دیریگب سامت هدش دیق امش ییاسانش

Úयान द: यिद आप ंहदी (Hindi) बोलत ह, आपको भाषा सहायता सबाए, ंन:शãक उपलÞध ह। कपया अपन पहचान पत्र पर सचीबद्ध टोल-फ्री फोन नबर पर कॉल कर।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចណាបអារមណ: ៖ បសនអកនយយភសា ែខ (Khmer) ៖ សវាជនយភសា ៖ ដាយឥតគតថ គមានសរាបអក។ សមទរសពទៅ ៖ លខឥតគតថ ែដលមាននៅ ៖ លអតសញ្ញាណបណរបសអក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh hane'íbiká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaag