Oberlin College

Group Number – 590467

2024 Evidence of Coverage

MedMutual Advantage PPO Plan

600664

This Evidence of Coverage includes information on standard rules and processes for a Medical Mutual Medicare Advantage plan. However, there may be situations where the plan rules as outlined here differ from those of your former employer or retiree group.

For plan-specific information, please be sure to review your other plan materials or contact Customer Care at the number on the back of this booklet.

January 1 - December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of the MedMutual Advantage PPO Plan.

This document gives you the details about your Medicare health care coverage from January 1 - December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Care at 1-800-801-4823. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). This call is free.

This plan, *MedMutual Advantage PPO,* is offered by Medical Mutual of Ohio (Medical Mutual). (When this *Evidence of Coverage* says "we," "us," or "our," it means Medical Mutual. When it says "plan" or "our plan," it means *MedMutual Advantage PPO.)*

This document is available in alternate formats (e.g., braille, large print, audio).

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

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

2024 Evidence of Coverage
Table of Contents

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in MedMutual Advantage PPO, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, MedMutual Advantage PPO. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

MedMutual Advantage PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

For information on plan changes that may be available during the Group Open Enrollment Period, contact your group's benefit administrator.

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

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

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

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of MedMutual Advantage PPO.

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

If you are confused or concerned, or just have a question, please contact Customer Care.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in MedMutual Advantage PPO between January 1, 2024 and December 31, 2024.

Each year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of MedMutual Advantage PPO after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

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

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

Section 2.1 Your eligibility requirements

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

1. Your group's benefit administrator determines you are eligible. (For questions about your group's eligibility rules, please contact your group's benefit administrator.)
2. You have both Medicare Part A and Medicare Part B
   - -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
   - -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for MedMutual Advantage PPO

MedMutual Advantage PPO is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes all 50 states. We offer coverage in all states and U.S. territories.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Care to see if we have a plan in your new area.

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

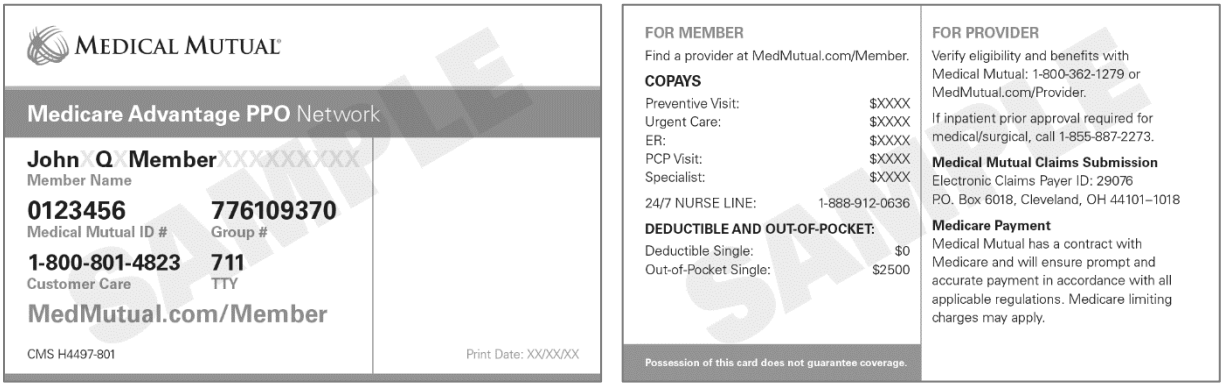
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your MedMutual Advantage PPO membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider Directory

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

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan for your medical services*) for more specific information.

If you need to seek covered services from providers who are outside Ohio or in the following Ohio counties (in other words, from an out-of-network provider), your plan provides in-network coverage for these services, but only if the provider is eligible to participate in Medicare. These counties are Ashtabula, Athens, Belmont, Jefferson, Lawrence, and Meigs. To find a provider when you are in one of these Ohio counties or are outside Ohio, call Customer Care at 1-800-801-4823 or use the provider search tool at www.medicare.gov.

The most recent list of providers and suppliers is available on our website at MedMutual.com/MAgroup.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Care. Requests for hard copy Provider Directories will be mailed to you within three business days.

SECTION 4 Your monthly costs for MedMutual Advantage PPO

Your costs may include the following:

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

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of ***Medicare & You 2024*** handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

Section 4.2 Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

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

SECTION 5 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

If any of this information changes, please contact your group's benefit administrator, or if so directed by that administrator, Customer Care.

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

SECTION 6 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 MedMutual Advantage PPO contacts (how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care
For assistance with claims, billing, or member card questions, please call or write to MedMutual Advantage PPO Customer Care. We will be happy to help you.

Method	Customer Care - Contact Information
CALL	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
WRITE	Medical Mutual Attn: Customer Care P.O. Box 94563 Cleveland, OH 44101-4563
WEBSITE	MedMutual.com/MAgroup

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

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

Method	Coverage Decisions and Appeals for Medical Care - Contact Information
CALL	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. 1-855-887-2273 to request an expedited organization determination or expedited appeal only. Available Monday through Friday, 8 a.m. to 5 p.m.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
FAX	1-844-606-5394 for standard appeals 1-800-221-2640 for expedited organization determinations or expedited (“fast track”) appeals only
WRITE	For coverage determinations: Medical Mutual MZ 02-3P-7516 100 American Road Cleveland, OH 44144-2322 For expedited determinations: Medical Mutual Attn: Medicare Care Management MZ 02-3P-3982 100 American Road Cleveland, OH 44144-2322 For appeals: Medical Mutual Attn: Medicare Advantage Appeals & Grievances Department P.O. Box 94563 Cleveland, OH 44101-4563
WEBSITE	MedMutual.com/Member For appeals: Log in to My Health Plan, and select "Resources & Tools" and then "Forms."

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

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

Method	Complaints about Medical Care - Contact Information
CALL	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
FAX	1-844-606-5394
WRITE	Medical Mutual Attn: Medicare Advantage Appeals & Grievances Department P.O. Box 94563 Cleveland, OH 44101-4563
MEDICARE WEBSITE	You can submit a complaint about MedMutual Advantage PPO directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/my/medicare-complaint.

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

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

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

Method	Payment Requests - Contact Information
WRITE	Medical Mutual P.O. Box 6018 Cleveland, OH 44101-1018
WEBSITE	MedMutual.com/MAgroup

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

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

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

Method	Medicare - Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information.

	• **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about MedMutual Advantage PPO: • **Tell Medicare about your complaint:** You can submit a complaint about MedMutual Advantage PPO directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Each SHIP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans. Please see Appendix 1 to find the SHIP for your state.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page).
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state and U.S. territory. Please see below for your state or territory's Quality Improvement Organization.

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

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

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

KEPRO is the Quality Improvement Organization for the following states and territories: Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, and Wyoming.

KEPRO Contact Information TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.	
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	
Address/Website	**Phone**
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 www.keproqio.com	1-888-319-8452 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	
Address/Website	**Phone**
KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 www.keproqio.com	1-888-317-0751 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available. TTY 1-855-843-4776
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	
Address/Website	**Phone**
KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 www.keproqio.com	1-888-315-0636 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776

KEPRO Contact Information **TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.**	
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	
Address/Website	**Phone**
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 www.keproqio.com	1-888-317-0891 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776
Region 10: Alaska, Idaho, Oregon, Washington	
Address/Website	**Phone**
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 www.keproqio.com	1-888-305-6579 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776

Livanta is the Quality Improvement Organization for the following states and territories: Arizona, California, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, Ohio, Pacific Territories, Pennsylvania, Puerto Rico, U.S. Virgin Islands, Virginia, West Virginia, and Wisconsin.

Livanta Contact Information TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.	
Region 2: New Jersey, New York, Puerto Rico, U.S. Virgin Islands	
Address/Website	**Phone**
Livanta BFCC-QIO Program 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 11:00 a.m. - 3:00 p.m. (local time) 24-hour voicemail service is available TTY 1-866-868-2289
Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	
Address/Website	**Phone**
Livanta BFCC-QIO Program 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-396-4646 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 11:00 a.m. - 3:00 p.m. (local time) 24-hour voicemail service is available TTY 1-888-985-2660
Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	
Address/Website	**Phone**
Livanta BFCC-QIO Program 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-524-9900 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 11:00 a.m. - 3:00 p.m. (local time) 24-hour voicemail service is available TTY 1-888-985-8775

Livanta Contact Information TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.	
Region 7: Iowa, Missouri, Kansas, Nebraska	
Address/Website	**Phone**
Livanta BFCC-QIO Program 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-888-755-5580 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 11:00 a.m. - 3:00 p.m. (local time) 24-hour voicemail service is available TTY 1-888-985-9295
Region 9: Arizona, California, Hawaii, Nevada, Pacific Territories (American Samoa, Guam, Northern Mariana Islands)	
Address/Website	**Phone**
Livanta BFCC-QIO Program 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-877-588-1123 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 11:00 a.m. - 3:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-887-6668

SECTION 5 Social Security

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

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

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

SECTION 6 Medicaid

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

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

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

To find out more about Medicaid and its programs, contact your state department of Medicaid, listed in Appendix 2.

SECTION 7 How to contact the Railroad Retirement Board

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

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

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

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

CHAPTER 3:

Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

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

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

As a Medicare health plan, MedMutual Advantage PPO must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

MedMutual Advantage PPO will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
    - The providers in our network are listed in the *Provider Directory*.
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.

- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

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

1. A PCP is your Primary Care Physician. When you become a member of our plan, you will be asked to select a network physician to be your PCP. A PCP is a physician who meets state requirements and is trained to give you basic medical care. He or she is generally most familiar with your medical condition and history. Your PCP may also coordinate the rest of the covered services you get as a plan member, but you do not need to get a referral from your PCP to see other network physicians.
2. What types of providers may act as a PCP?
   PCPs are generally physicians specializing in internal medicine, family practice, general practice or geriatric medicine.
3. What is the role of my PCP?
   Your relationship with your PCP is important, because your PCP is responsible for routine health care needs and may help coordinate your covered services. Coordinating your services includes consulting with other providers about your care and how it is progressing.

How do you choose your PCP?

When you become a member of our plan, we will ask you to choose a network provider to be your PCP when you fill out your enrollment application. You can use our *Provider Directory* to select your PCP or you may contact Customer Care.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services. Be aware that changing your PCP may result in your being limited to specific hospitals with which your PCP has admitting privileges.

To change your PCP, simply call Customer Care. You can also change your PCP by visiting our secure member site at MedMutual.com/Member.

If the new PCP is accepting new members, the transfer will become effective on the day we receive your request.

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

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

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

You do not need a referral to see specialists or other network providers. However, we encourage you to first see your PCP, if you have selected one. Your PCP can help coordinate your health care needs with specialists and other providers. In addition, certain services require prior authorization from the plan. Your provider is responsible for obtaining this prior authorization.

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

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization may apply. Please contact Customer Care for more information.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider when you receive services in any Ohio county except for Ashtabula, Athens, Belmont, Jefferson, Lawrence, and Meigs, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.
- When you are outside our network area or outside Ohio and need to obtain covered services, your plan provides in-network coverage for these services, but only if the provider is eligible to participate in Medicare. To find a provider when you are in one of these Ohio counties (Ashtabula, Athens, Belmont, Jefferson, Lawrence, and Meigs) or are outside Ohio, call Customer Care at the number on the back of this booklet or use the provider search tool at www.medicare.gov.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. This coverage is worldwide.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please contact our Care Management department toll free at 1-855-887-2273 between the hours of 8 a.m. and 5 p.m., Monday through Friday. If calling at other times, please leave a voice message.

What is covered if you have a medical emergency?

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

For care received in all Ohio counties except for Ashtabula, Athens, Belmont, Jefferson, Lawrence, and Meigs, if you use an out-of-network provider, you may pay a higher share of the costs for your care. For care received outside Ohio or in Ashtabula, Athens, Belmont, Jefferson, Lawrence, and Meigs counties, you can receive in-network coverage for plan-covered services from a provider who is eligible to participate in Medicare.

When urgent care is needed and network providers are temporarily unavailable or inaccessible, proceed to the nearest urgent care center for immediate treatment. You can find in-network urgent care centers in our *Provider Directory* by going to MedMutual.com/MAgroup or by calling Customer Care at 1-800-801-4823.

You can also call our Nurse Line toll free at 1-888-912-0636 to speak with a registered nurse who can answer your questions or direct you to the appropriate next step. Our nurses are available 24 hours per day, 7 days per week for advice.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: You are traveling outside the United States for less than six months. Please see “Emergency care” and “Urgently needed services” in the Medical Benefits Chart in Chapter 4 for more details.

Section 3.3 Getting care during a disaster

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

Please visit the following website: MedMutual.com/MAgroup for information on how to obtain needed care during a disaster.

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

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

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

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

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

MedMutual Advantage PPO covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any costs you pay after a benefit limit has been reached will not count toward your out-of-pocket maximum for services over the limit.

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

Section 5.1 What is a clinical research study?

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

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

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

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, which is the same amount you would pay under our plan’s benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan, such as a provider bill.

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

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

Do you want to know more?

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

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

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

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

Section 6.2 Receiving care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - *- and -* you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (see the *Medical Benefits Chart* in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of MedMutual Advantage PPO, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Care for more information.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, MedMutual Advantage PPO will cover:

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

If you leave MedMutual Advantage PPO or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

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

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

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

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

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

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- **Copayment** is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is your plan deductible?

Your deductible is $500. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. See the "What you must pay" column of the Medical Benefits Chart in Section 2.1 to see which services have a deductible and which do not.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services.

- Your **in-network maximum out-of-pocket amount (MOOP)** is $3,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart). If you have paid $3,000 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,000 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to balance bill you

As a member of MedMutual Advantage PPO, an important protection for you is that after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

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

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

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

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from MedMutual Advantage PPO.
- Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
    - Artificial Heart Systems
    - Artificial Limbs and Prosthetic Devices
    - Bone Growth Stimulators
    - Carotid Artery Stenting
    - Cochlear Implant
    - Electrical Stimulation and Electromagnetic Therapy for Ulcers
    - Genetic Testing
    - Hyperbaric Therapy
    - Lumbar Spinal Fusion
    - Transcatheter Valve Replacement/Implantation
    - Transplants - Bone Marrow, Organs and Stem Cell
    - Uterine Artery Embolization for Treatment of Fibroids
    - Varicose Vein: Surgical Treatment and Sclerotherapy
    - Ventricular Assist Devices
- You never need approval in advance for out-of-network services from out-of-network providers.
- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your ***Medicare & You 2024*** handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
For services that have member cost-sharing, providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: • Your doctor will ask for a copayment for the office visit and additional copayments for each x-ray that is performed while you are there. • Your hospital will ask for separate cost sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there. • Your pharmacist will ask for a separate copayment or coinsurance for each prescription he or she fills. • The specific cost sharing that will apply depends on which services you receive and how those services are billed by the provider. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as	Auxiliary personnel, such as chiropractors and acupuncturists, may perform acupuncture sessions for you as long as these sessions are supervised and billed by a physician who is currently treating you for chronic lower back pain. **In Network and Out of Network** 15% coinsurance for each covered acupuncture service in a primary care physician's office 15% coinsurance for each covered acupuncture service in a specialist's office **Prior authorization rules may apply. Please contact the plan for details.**

Services that are covered for you	What you must pay when you get these services
identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Allergy testing and treatment Your plan covers allergy testing and treatment performed and related to a specific diagnosis.	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for allergy testing. 15% coinsurance for allergy treatment
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for covered one-way ambulance services. **Prior authorization rules may apply. Please contact the plan for details.**
Annual physical exam In addition to the Medicare-covered annual wellness visit listed below, your plan also covers one annual physical exam per calendar year.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for each covered physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the annual wellness visit.

Services that are covered for you	What you must pay when you get these services
Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In Network and Out of Network** For each covered therapy visit to treat you if you've had a heart condition, you pay 15% coinsurance. This type of therapy is called cardiac rehabilitation or intensive cardiac rehabilitation. **Prior authorization rules may apply. Please contact the plan for details.**
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services (Medicare-covered) Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In Network and Out of Network** 15% coinsurance for each visit that Original Medicare covers to see a chiropractor.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. You pay 0% coinsurance for covered barium enemas.

Services that are covered for you	What you must pay when you get these services
months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Dental services (Medicare-covered) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. Medicare covers: • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease • Services that would be covered when provided by a doctor	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for covered dental services.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Services that are covered for you	What you must pay when you get these services
meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for covered training to help you learn how to monitor your diabetes. There is no coinsurance, copayment, or deductible for the following diabetic supplies: • A blood glucose meter (excluding continuous glucose monitors) • Blood glucose test strips • Lancing devices and glucose lancets • Glucose control solutions for checking the accuracy of test strips and glucose meters and glucose monitors. There is no coinsurance, copayment, or deductible for all other diabetic supplies. **Certain supplies considered durable medical equipment may be subject to prior authorization. Please contact the plan for details.**
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at MedMutual.com/MAgroup.	If you receive a durable medical equipment item during an inpatient stay (in a hospital or skilled nursing facility), the cost of the item will be included in your inpatient claim. You must get durable medical equipment through our participating plan suppliers. You cannot purchase these items from a pharmacy. **In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for durable medical equipment. After the $500 deductible is met, your cost sharing for Medicare oxygen equipment coverage is 15% every month. Your cost sharing will not change after being enrolled for 36 months. There is no coinsurance, copayment, or

Services that are covered for you	What you must pay when you get these services
	deductible for the following diabetic supplies: • A blood glucose meter (excluding continuous glucose monitors) • Blood glucose test strips • Lancing devices and glucose lancets • Glucose control solutions for checking the accuracy of test strips and glucose meters and glucose monitors. There is no coinsurance, copayment, or deductible for all other diabetic supplies. **Certain supplies considered durable medical equipment may be subject to prior authorization. Please contact the plan for details.**
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. This coverage is worldwide. You pay a $120 copayment for each emergency visit to a hospital outside the United States. This applies if you are traveling outside the United States for less than six months. Worldwide emergency/urgently needed services are limited to $50,000 per calendar year. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit receipts to Medical Mutual for reimbursement. For more information, please see Chapter 5. We may	**In Network and Out of Network** $120 copayment for each covered emergency room visit. If you are admitted to the hospital within 24 hours, you do not have to pay the $120 copayment. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.

Services that are covered for you	What you must pay when you get these services
not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than providers outside of the U.S. and its territories.	
Health and wellness education programs **Chronic Condition Management Program** This program can help you stay healthy, manage your chronic conditions and maintain your independence. A trained health coach, including digital options, works with you to develop a personalized plan that supplements the care you get from your doctor. For more information, call Customer Care at 1-800-801-4823. **Nurse Line** If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line toll free at 1-888-912-0636, 24 hours per day, seven days per week for advice. Your call is kept confidential. **SilverSneakers® Fitness Program** SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note that nonstandard fitness center services that usually have an extra fee are not included in your membership. To take advantage of the program, you'll need your SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY 711 for hearing impaired) Monday through Friday, 8 a.m. to 8 p.m. **WeightWatchers® Program** To help you meet your health goals, we partner with WeightWatchers, the world's leading provider of weight management services. Monthly WeightWatchers membership fees for specified programs are reduced for MedMutual Advantage PPO members. The benefit does not include food or meals. For more information, contact Customer	There is no coinsurance, copayment, or deductible for the Chronic Condition Management Program, Nurse Line or SilverSneakers. You pay 70% coinsurance for the WeightWatchers Program.

Services that are covered for you	What you must pay when you get these services
Care at 1-800-801-4823.	
Hearing services (Medicare-covered) Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	**In Network and Out of Network** 15% coinsurance for each Medicare covered hearing exam. If additional medical services, procedures or tests are provided at the time of the visit, additional copayments may apply to those specific services rendered.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home-based palliative care Designed to provide relief and comfort in a home-based setting, this multi-disciplinary specialty medical and nursing program is available for members who have been diagnosed with an advanced illness to help improve their quality of life as they manage their treatment plan. This supportive service is offered through Aspire Health, as well as network provider partners, whose teams can help coordinate care with your own PCP and/or specialist(s). For more information or to find out if you are eligible for this program, call Aspire Health toll free at 1-844-232-0500 (TTY 866-669-7707 for hearing impaired). Covered services include: • **Extra care** – the clinical team is available 24 hours a day, 7 days a week. The team visits patients in their homes and can prescribe medicine when necessary to manage symptoms such as fatigue, nausea, shortness of breath, difficulty sleeping, or pain. • **Coordination with current providers** – the clinical team works closely with your existing providers, and can find additional resources that may be beneficial to your family, such as financial, transportation, and meal support.	There is no coinsurance, copayment, or deductible for covered home-based palliative care services.

Services that are covered for you	What you must pay when you get these services
• **Care goals** – the team works with you and your family to identify your healthcare goals, and aligns your care with these goals. • **Education** – the team can provide education to you and your family about your illness, plan of care, medications and much more to help you and your family plan for future care needs.	
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for Medicare-covered home health agency care. **Prior authorization rules may apply. Please contact the plan for details.**
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance **or less** for home infusion therapy drugs. Please see the “Medicare Part B Prescription Drugs” listing for additional information. After the $500 deductible is met, you pay 15% coinsurance for home infusion equipment and supplies.

Services that are covered for you	What you must pay when you get these services
Home Meals Program After your inpatient stay in a hospital, you are eligible to receive a one-week course of meals, at no extra cost to you. You will receive two meals a day for seven days delivered to your home. The home meal benefit must be requested and authorized within 30 days of discharge from an acute inpatient hospital. For more information about Home Meals or to find out if you are eligible, please contact Customer Care at 1-800-801-4823.	There is no coinsurance, copayment, or deductible for the Home Meals Program. **Prior authorization rules may apply. Please contact the plan for details.**
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you choose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not MedMutual Advantage PPO.

Services that are covered for you	What you must pay when you get these services
Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization): • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services. For services that are covered by MedMutual Advantage PPO but are not covered by Medicare Part A or B: MedMutual Advantage PPO will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. The shingles shot is not covered under the Part B drug benefit. Contact Customer Care at 1-800-801-4823 for more information.
Inpatient hospital care There is no limit to the number of days covered by the plan. Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	For covered hospital stays: Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities and Inpatient Acute Care facilities. **In Network and Out of Network** Day 1 and thereafter: After the $500

Services that are covered for you	What you must pay when you get these services
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MedMutual Advantage PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician services **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	deductible is met, you pay 15% coinsurance **Prior authorization rules may apply. Please contact the plan for details.** For an emergency admission, you or the hospital should tell the plan within one business day of the admission, if possible. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	A benefit period starts on the first day you go into a hospital. The benefit period ends when you haven't had any inpatient hospital care for 60 days in a row. The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days. **In Network and Out of Network** For covered hospital stays: Days 1 - 90: After the $500 deductible is met, you pay 15% coinsurance **Prior authorization rules may apply. Please contact the plan for details.**
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay The plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached this coverage limit, the plan will no longer cover your stay in the SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services	**In Network and Out of Network** You must pay the full cost if you stay in a hospital or skilled nursing facility longer than your plan covers. If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this booklet.

Services that are covered for you	What you must pay when you get these 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	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Step therapy applies to drugs in the following categories. For additional details please visit the link below. • Cancer and other conditions associated with oncology treatment • Bone disorders	**<u>In Network and Out of Network</u>** After the $500 deductible is met, you pay 15% coinsurance **or less** for chemotherapy drugs, biologicals and other drugs covered by Medicare Part B – including their administration and all chemotherapy services. If your drug is listed with Part B Rebatable Drug Pricing adjustments on the most recent quarterly report published by the Centers for Medicare & Medicaid Services (CMS), then you will pay less than 15% coinsurance. The actual coinsurance percentage will vary based on the cost of your drug, but will NOT be more than 15%. The Part B drugs identified with pricing adjustments are those with prices increasing faster than inflation. You still have to pay your portion of the cost allowed by the plan for a Part B drug whether you get it from a doctor's office or a pharmacy. Medicare Part B prescription drugs may be subject to step therapy requirements, meaning that you may be asked to try a different drug first before we will agree to cover the drug you are asking for. You pay no more than a $35 copayment for a one-month supply of insulin. **Prior authorization rules may apply. Please contact the plan for details.**

Services that are covered for you	What you must pay when you get these services
• Inflammatory conditions • Joint disorders • Eye disorders • Blood and cell disorders • Other drugs may be added and will be updated with at least 30 days' notice at the link below. The following link will take you to a list of Part B drugs that may be subject to Step Therapy: MedMutual.com/MAgroup.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for each covered outpatient counseling or therapy visit, including intake and periodic assessments. 15% coinsurance for each covered outpatient toxicology test After the $500 deductible is met, you pay 15% coinsurance for FDA-approved opioid agonist and antagonist treatment medications and dispensing. **Prior authorization rules may apply. Please contact the plan for details.**
Other outpatient services • Home infusion/specialty drug administration • Hyperbaric therapy or respiratory therapy • Private duty nursing	**In Network and Out of Network** 15% coinsurance for specialty drug administration in a physician's office, or 15% coinsurance after the $500 deductible is met for home infusion. After the $500 deductible is met, you pay 15% coinsurance for hyperbaric therapy or respiratory therapy. After the $500 deductible is met, you pay 15% coinsurance for private duty nursing.

Services that are covered for you	What you must pay when you get these services
• Weight loss surgical services (bariatric surgery), including any repairs, revisions, or modifications of such surgery	After the $500 deductible is met, you pay 15% coinsurance for weight loss surgical services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Other outpatient diagnostic tests	Please Note: You may have to pay a copayment for an office visit if you get other services during the visit. If you need to pay a copayment, the copayment will be based upon each date of service and each provider. For services in this category that have a coinsurance, the coinsurance will be applied per service. **In Network and Out of Network** Laboratory Services • 15% coinsurance for each covered laboratory service X-ray Services • For each covered x-ray service, including diagnostic mammogram, you pay 15% coinsurance. Ultrasound Services • For each covered ultrasound, you pay 15% coinsurance. Therapeutic Radiology Services (such as radiation therapy for cancer) • For each covered therapeutic radiology service, after the $500 deductible is met, you pay 15% coinsurance. Original Medicare Covered Diagnostic Tests and Procedures • 15% coinsurance for each Original Medicare covered diagnostic test or procedure, such as heart catheterizations and sleep studies Diagnostic Radiological Services • For each covered Computed Tomography (CT) scan; Magnetic Resonance test (MRI and MRA); or nuclear medicine study, including PET scans, you pay 15% coinsurance. Blood, Blood Storage and Processing and Handling Services • After the $500 deductible is met, you pay 15% coinsurance for each covered blood,

Services that are covered for you	What you must pay when you get these services
	blood storage, processing and handling service. Surgical Supplies • After the $500 deductible is met, you pay 15% coinsurance for each surgical supply, such as casts and splints. Test to Confirm Chronic Obstructive Pulmonary Disease (COPD) • 15% coinsurance for each covered test to confirm COPD **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for observation services.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:	Please Note: You may have to pay a copayment for an office visit if you get other services during the visit. If you need to pay a copayment, the copayment will be based upon each date of service and each provider. For services in this category that have a

Services that are covered for you	What you must pay when you get these services
• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	coinsurance, the coinsurance will be applied per service. **In Network and Out of Network** $120 copayment for each covered emergency room visit 15% coinsurance for each covered laboratory service After the $500 deductible is met, you pay 15% coinsurance for each covered mental health care visit. After the $500 deductible is met, you pay 15% coinsurance for each covered intensive outpatient service visit or partial hospitalization visit for mental health or substance abuse. For each covered medical x-ray, including diagnostic mammogram, you pay 15% coinsurance. For each covered ultrasound, you pay 15% coinsurance. 15% coinsurance for Original Medicare covered diagnostic tests and procedures, such as heart catheterizations and sleep studies For each covered Computed Tomography (CT) scan; Magnetic Resonance test (MRI and MRA); or nuclear medicine study, including PET scans, you pay 15% coinsurance. 15% coinsurance for each covered surgery or surgical procedure performed as an outpatient at a hospital 15% coinsurance for each covered surgery or surgical procedure performed at an ambulatory surgical center For each covered therapeutic radiology service, after the $500 deductible is met, you pay 15% coinsurance. After the $500 deductible is met, you pay 15% coinsurance for covered medical supplies such as splints and casts when you get them in the outpatient department of a hospital. There is no coinsurance, copayment, or deductible for certain covered screenings and

Services that are covered for you	What you must pay when you get these services
	preventive services to detect or avoid disease. After the $500 deductible is met, you pay 15% coinsurance **or less** for chemotherapy drugs, biologicals and other drugs covered by Medicare Part B - including their administration and all chemotherapy services. These drugs may be subject to step therapy requirements. Please see the "Medicare Part B Prescription Drugs" listing for additional information. 15% coinsurance for each covered test to confirm COPD **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT),nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In Network and Out of Network** 15% coinsurance for each covered physical therapy, occupational therapy, or speech/language therapy visit. **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient substance abuse services Coverage is available for treatment services that are provided in an ambulatory setting to patients who, for example, have been discharged from an inpatient stay for the treatment of substance abuse or who require treatment but do not require the intensity of services found only in the inpatient hospital setting. Traditional Outpatient treatment is a level of care in which a licensed mental health professional provides care to individuals in an outpatient setting, whether to the patient individually, in family therapy, or in a group	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy.

Services that are covered for you	What you must pay when you get these services
modality either in a professional office or in a hospital outpatient clinic or program.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an *outpatient*.	**In Network and Out of Network** 15% coinsurance for each covered surgery or surgical procedure performed as an outpatient at a hospital 15% coinsurance for each covered surgery or surgical procedure performed at an Ambulatory Surgical Center You pay no coinsurance, copayment, or deductible for a screening exam of the colon when it includes a biopsy or removal of any growth during the procedure. In this case, when you get these services from a provider in our network, you do not have to pay the outpatient surgery or ambulatory surgical center coinsurance. **Prior authorization rules may apply. Please contact the plan for details.**
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor’s or therapist’s office but less intense than partial hospitalization.	**In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for each covered partial hospitalization visit or intensive outpatient service visit.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist if your doctor orders	**In Network and Out of Network** 15% coinsurance for each covered PCP visit 15% coinsurance for each covered specialist visit (including office visits to psychologists and psychiatrists; and non-routine dental care) Additional copays or coinsurance may apply if other services are received during the same visit. After any applicable physician’s office visit

Services that are covered for you	What you must pay when you get these services
it to see if you need medical treatment. • Certain telehealth services, including: primary care physician services and physician specialist services o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. o Telehealth services must have an audio, video, or other electronic component, and the provider must determine that care can be provided in this format. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and**	copayments, you pay no copayment for each covered surgery or surgical procedure performed in a doctor's office. **Prior authorization rules may apply. Please contact the plan for details.**

Services that are covered for you	What you must pay when you get these services
○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs Although the following preventive services are not covered by Original Medicare, your plan covers: routine foot care for peripheral vascular disease or diabetes (up to a maximum of $700 per benefit period)	**In Network and Out of Network** 15% coinsurance for each Original Medicare covered podiatry visit After any applicable physician's office visit copayments, you pay no copayment for each covered foot surgery or surgical procedure performed in a doctor's office. **Prior authorization rules may apply. Please contact the plan for details.** After the $500 deductible is met, you pay 15% coinsurance for routine foot care for peripheral vascular disease or diabetes.
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are	You must get prosthetic devices and the supplies that go with them from a supplier who works with this plan. You cannot

Services that are covered for you	What you must pay when you get these services
not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see *Vision Care* later in this section for more detail.	purchase these items from a pharmacy. If you buy them from a pharmacy they will not be covered. **In Network and Out of Network** After the $500 deductible is met, you pay 15% coinsurance for prosthetic devices and supplies. **Prior authorization rules may apply. Please contact the plan for details.**
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In Network and Out of Network** 15% coinsurance for each covered visit **Prior authorization rules may apply. Please contact the plan for details.**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 - 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for each covered visit to learn about kidney care and how to care for yourself if you need kidney dialysis. After the $500 deductible is met, you pay 15% coinsurance for covered dialysis equipment or supplies. After the $500 deductible is met, you pay 15% coinsurance for kidney dialysis when you use a network provider or you are temporarily out of the service area. You pay only the inpatient hospital copayment for dialysis when received as an inpatient. You do not need to get an approval from the

Services that are covered for you	What you must pay when you get these services
dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, *Medicare Part B prescription drugs*.	plan before getting dialysis. But, please let us know when you need to start this care, by calling our Care Management department toll free at 1-855-887-2273, so we can help coordinate with your doctors.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) We will pay for skilled nursing facility care for up to 100 days per benefit period. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	**<u>In Network and Out of Network</u>** For covered SNF stays: Days 1 - 100: After the $500 deductible is met, you pay 15% coinsurance. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended a new benefit period begins. There is no limit on how many benefit periods of coverage you can have. **Prior authorization rules may apply. Please contact the plan for details.**

Services that are covered for you	What you must pay when you get these services
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. Your plan also gives you access to our tobacco QuitLine, at no additional cost to you. Call toll free 1-866-845-7702 (TTY 711 for hearing impaired) to sign up. Once you enroll, a trained coach will work with you on a quit plan and provide one-on-one support. Five telephonic coaching calls are included in the program. You can also receive a supply of nicotine replacement therapy, in the form of patches or gum, at no cost. You can call as many times as you need for additional support.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits or tobacco QuitLine.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting	**In Network and Out of Network** 15% coinsurance for each covered SET visit **Prior authorization rules may apply. Please contact the plan for details.**

Services that are covered for you	What you must pay when you get these services
or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Urgent care services are worldwide. You pay a $30 copayment for each urgent care center visit outside the United States. This applies if you are traveling outside the United States for less than six months. Worldwide emergency/urgently needed services are limited to $50,000 per calendar year.	**In Network and Out of Network** $30 copayment for each covered urgent care center visit For urgently needed services received at a PCP's or specialist office, please see the office visit copayments listed under "Physician/Practitioner services."

Services that are covered for you	What you must pay when you get these services
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) **Although the following vision services are not covered by Original Medicare, your plan covers:** • Eye refractions associated with a Medicare-covered eye exam	**In Network and Out of Network** 15% coinsurance for Original Medicare covered eye exams and screenings Eye refractions have the same cost-sharing as Original Medicare covered eye exams – see additional non-Medicare vision services covered by your plan below. After the $500 deductible is met, you pay 15% coinsurance for Original Medicare covered eyeglasses or contact lenses after cataract surgery. **In Network and Out of Network** 15% coinsurance for each covered eye refraction.
Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	**In Network and Out of Network** There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

SECTION 3 What services are not covered by the plan?

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances. Refer to the "Acupuncture for chronic low back pain" benefit in the Medical Benefits Chart in Section 2.1 for details.
Any non-emergency or non-urgent care received outside of the United States and the U.S. Territories	**Not covered under any condition**	
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial 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	**Not covered under any condition**	
Diagnostic services performed in a chiropractor's office	**Not covered under any condition**	
Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy	**Not covered under any condition**	
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, support stockings and other primarily non-medical equipment	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	**Not covered under any condition**	
Full-time nursing care in your home	**Not covered under any condition**	
Home-delivered meals		After your inpatient stay in a hospital, you are eligible to receive a one-week course of meals, at no extra cost to you. You will receive two meals a day for seven days delivered to your home.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	**Not covered under any condition**	
Immunizations for foreign travel purposes	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition** Although naturopath services are not covered, acupuncture is covered under specific conditions. See above.	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to, home and car remodeling or modification, and exercise equipment	**Not covered under any condition**	
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Over-the-counter purchases, unless such services are specifically listed in the benefits section of this agreement	**Not covered under any condition**	
Patient convenience transfers between skilled nursing facilities and hospitals, including any transportation, facility or physician charges associated with such	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	**Not covered under any condition**	
Private room in a hospital		Covered only when medically necessary.
Procedures, services, supplies and medications until they are reviewed for safety, efficacy and cost-effectiveness, and approved by Medicare and Medical Mutual	**Not covered under any condition**	
Reversal of sterilization procedures and or non-prescription contraceptive supplies	**Not covered under any condition**	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures	**Not covered under any condition**	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		Your plan provides some limited coverage based on Medicare guidelines (e.g., if you have diabetes) and for peripheral vascular disease or diabetes. See the Medical Benefits Chart in Section 2.1 for details.
Routine hearing exams, hearing aids, or exams to fit hearing aids	**Not covered under any condition**	
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services that are not covered under Original Medicare, unless such services are specifically listed in the benefits section of this agreement	**Not covered under any condition**	
Services you get without prior authorization when prior authorization is required for such services	**Not covered under any condition**	
Transports by wheelchair van or ambulette and trips to or from a physician's office	**Not covered under any condition**	
Treatment for injuries received while engaged in an illegal activity	**Not covered under any condition**	

CHAPTER 5:

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

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

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

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

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

1. **When you've received medical care from a provider who is not in our plan's network**
   When you receive care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.
   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
   - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.
2. **When a network provider sends you a bill you think you should not pay**
   Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

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

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

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

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

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

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

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

- You don't have to use the form, but it will help us process the information faster. Be sure to include your name, date of service, total charge, description of services rendered along with any corresponding codes (diagnosis and procedure codes), as well as provider of service name and location where services were rendered.
- Either download a copy of the form from our website (MedMutual.com/Member) or call Customer Care and ask for the form.

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

Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018

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

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

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

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

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

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

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

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Care at 1-800-801-4823. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights (1-800-368-1019 or TTY 1-800-537-7697).

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

You have the right to choose a provider for your care.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

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

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

- Your *personal health information* includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

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

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

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

NOTICE OF PRIVACY PRACTICES

Your Privacy Is Important to Us

Medical Mutual has always been committed to protecting the information you share with us. Medical Mutual is required by law to maintain the privacy of your personal information as well as your protected health information, and to provide you with this Notice of Privacy Practices (this "Notice") describing our legal duties and privacy practices with respect to your information. This Notice applies to Medical Mutual of Ohio and its Family of Companies, which includes MedMutual Life Insurance Company and Medical Health Insuring Corporation of Ohio. This Notice also applies to our wholly owned subsidiaries Medical Mutual Services, LLC and Mutual Health Services, a division of Medical Mutual Services, LLC, as applicable, in their capacity as business associates to group health plans (herein referred to collectively as "Medical Mutual," "we," "our" or "us").

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

What Information We Collect

Medical Mutual understands your concerns about the confidentiality of information you share with us. We collect information from you on applications and other transactions with us. This information can include your name, address and Social Security number. Under certain conditions we may ask you and your covered dependents for medical history information. We also have access to your information through:

- Claims or lab results submitted to us from healthcare providers
- Information provided by your employer if your coverage is through an employer sponsored group health plan, and Information provided by your agent if you purchased your coverage through an agent.

How We Use and Disclose Your Information

We are permitted by law to use your information for certain purposes including treatment, payment and healthcare operations. Examples of how we may use and disclose your information include but are not limited to:

Treatment: Medical Mutual may use or disclose your information to aid in your treatment or the coordination of your care. For example, although we do not provide treatment, we may share your information with a healthcare provider to help the provider treat you.

Payment: Medical Mutual may use or disclose your information to determine your coverage and to pay claims for healthcare you receive. For example, we may provide eligibility information to your doctor when you receive treatment. We may also use or disclose your information to obtain payment of premiums or to coordinate benefits and payment with other entities that may have an obligation to pay for your healthcare.

Healthcare Operations: Medical Mutual may use or disclose your information for activities that are necessary to operate our business and ensure you receive quality services, like:

- Underwriting, premium rating or other activities relating to the creation or renewal of a health insurance contract
- Quality assessment and improvement activities such as peer review and credentialing of providers and other activities to improve the quality of the services we provide to you
- Care coordination and case and disease management activities, and
- Data and information systems management. For example, we may discuss with your doctor a disease management or wellness program appropriate for your condition. If Medical Mutual uses or discloses your information for underwriting purposes, we are prohibited by law from, and will not, use or disclose your genetic information for such purposes.

As Required by Law: Medical Mutual must allow the U.S. Department of Health and Human Services access to audit our records. In addition, Medical Mutual may release or disclose your information if we are required to do so to comply with other laws or for certain public policy purposes, including:

- To comply with legal proceedings, such as court orders, administrative orders or subpoenas
- To perform mandatory licensing and regulatory/compliance reporting
- To law enforcement officials for limited law enforcement purposes
- To federal officials for lawful intelligence, counterintelligence and other national security purposes
- To public health authorities for public health purposes
- To health oversight agencies for health oversight activities authorized by law, including audits, investigations, or licensure activities, and

- To comply with workers' compensation and other similar programs established by law that provide for benefits for work-related injuries or illness without regard to fault.

To Business Associates: Medical Mutual may disclose your information to third parties we hire to assist in the administration of your benefits. These third parties are called Business Associates, and they must agree in writing to protect and maintain the confidentiality and security of your information. Examples of a Business Associate are doctors who perform medical reviews and brokers who service your policy.

To Plan Sponsors: If you receive insurance benefits through a group plan, Medical Mutual may disclose to the plan sponsor, in summary form, claims history and other similar information about the group plan.

Such summary information does not disclose your name or other personally identifiable information. We may also disclose to the plan sponsor the fact you are enrolled in, or disenrolled from the group plan. We may disclose your information to the plan sponsor for administrative functions the plan sponsor provides to the group plan if the plan sponsor agrees in writing to ensure the continuing confidentiality and security of your information. The plan sponsor must also agree not to use or disclose your information for employment-related activities or for any other benefit or benefit plans of the plan sponsor.

To Organized Health Care Arrangements: Medical Mutual participates with certain healthcare providers in accountable care organizations that are organized health care arrangements to improve coordination and quality of care, reduce hospitalization, and better control healthcare costs. We may use and disclose your information to other participants in the accountable care organizations for the health care operations activities of the organization, such as to ensure care coordination, improve quality of care and control healthcare costs.

Other Uses and Disclosures: Medical Mutual may also disclose your information:

- To a personal representative appointed by you or designated by law
- To appropriate military authorities, if you are a member of the armed forces
- To a family member, friend or other person for the purpose of helping you with your healthcare or healthcare payment if you are in an emergency situation and you cannot give your agreement to Medical Mutual to do this or if you have had an opportunity to object and have not done so, or
- To provide you with appointment reminders and to inform you of treatment alternatives or other health related benefits or services that may be of interest to you.

Uses and Disclosures with Your Permission: Medical Mutual will not use or disclose your information for any purpose not outlined in this Notice unless you give Medical Mutual your written authorization to do so. Your authorization will be required for most of Medical Mutual's uses and disclosures of psychotherapy notes about you, uses and disclosures of your information for marketing purposes, and disclosures that constitute a sale of your information. If you give Medical Mutual your written authorization, you may revoke that authorization at any time. However, your revocation will have no effect on any action Medical Mutual previously took in reliance on your authorization. To receive an authorization form, please contact Customer Care at the number on your member identification (ID) card or print one from our website, MedMutual.com, **under the HIPAA section.** If a family member calls with knowledge of your claim, we may confirm certain information about it, unless you have informed us in writing of a need for confidential communication.

Your Rights

You have certain privacy and confidentiality rights as a member of Medical Mutual. Please note all requests described below must be made in writing. We have provided forms to help in processing your request. The appropriate forms are available under the HIPAA section on our website, MedMutual.com. You also may call Customer Care at the number on your member ID card to obtain copies of the appropriate forms. Hearing-impaired customers may contact us at 711 or 1-800-750-0750. All completed forms and requests are to be mailed to:

Medical Mutual of Ohio
P.O. Box 89499
Cleveland, OH 44101-6499

Requests with incomplete information will not be processed, and you will not be notified.

Restriction: You may request Medical Mutual place additional restrictions on the use and disclosure of your information to carry out treatment, payment or healthcare operations. Medical Mutual does not have to agree to your request. Please use the form provided under the HIPAA section on our website, MedMutual.com, to submit your request. Be sure to provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, and a clear explanation of your request. Medical Mutual will send a written confirmation about the disposition of your request.

Confidential Communications: You may request Medical Mutual communicate with you in confidence about your information at a different location or by a different means. Medical Mutual does not have to honor this request unless (1) such a change in communication is necessary to avoid endangering you; (2) your request allows Medical Mutual to continue to collect premiums and pay claims; and (3) your request is reasonable. Please use the form provided under the HIPAA section at the bottom of our website, MedMutual.com, to submit your request. Be sure to provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, the full address of where you would like future communications to be sent and the reason for the request. It will take 10 business days from the date we receive your request to process it. If we approve your request, you will receive a letter confirming the activation of the alternate address. Thereafter, all communications about your information will be sent to the alternate address until you notify us otherwise. Use of an alternate address cannot be applied to communications sent prior to our approval of your request.

Access to Your Information: You have a right to inspect and copy your information used and stored by Medical Mutual in its designated record set. For access to your entire medical record, you must contact the provider of service. Please use the form provided under the HIPAA section at the bottom of our website, MedMutual.com, to submit your request for access to your records. Be sure to provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, the information you would like to access and the dates of information you would like to see (if applicable).

Amend Your Information: You have the right to request an amendment of your information. Medical Mutual cannot amend information it did not create and will refer you to the provider of service if you are requesting an amendment to diagnosis or treatment information. Please use the form provided under the HIPAA section on our website, MedMutual.com, to submit your request to amend your records. Be sure to provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, the information you are requesting be amended, and an explanation as to why you believe the information is incorrect or incomplete. You have a right to an appeal if your request to an amendment is denied. These rights will be explained to you if your request is denied.

Disclosures: You have a right to an accounting of certain disclosures of your information made by Medical Mutual and its Business Associates over the last six years. Please use the form provided under the HIPAA section on our website, MedMutual.com, to submit your request for an accounting of disclosures of your records. Be sure to provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, and a statement explaining your specific request.

Fundraising: If Medical Mutual sends you a fundraising communication, you have a right to opt out of receiving future fundraising communications. Each communication will describe the opt-out mechanism.

Breach Notification: You have the right to, and will receive, notification from us following a breach of your unsecured protected health information. Such notice will describe what happened; the information that was breached, any steps you should take to protect yourself from potential harm, Medical Mutual's investigation and mitigation efforts, and contact information for questions.

Complaints: You have the right to complain if you believe your rights have been violated. You may use the form under the HIPAA section on our website, MedMutual.com, to submit your complaint. Please provide all required information including your name, the policy and group (if applicable) numbers under which you are covered, your birthdate, and an explanation about your complaint in as much detail as possible. You may file a complaint by contacting Customer Care at the number on your member ID card, if you wish not to send it in writing. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Federal law prohibits retaliation against you if you chose to file a complaint.

Contact Information: If you have questions or would like an additional copy of this Notice, please call the Customer Care number on your member ID card. Even if you have agreed to receive this Notice by electronic means, you still have the right to receive a paper copy.

Security Procedures

Medical Mutual takes the security of your information very seriously and has established security standards and procedures to prevent unauthorized access to your information. We maintain physical, technical and administrative safeguards to protect your information in any form, including oral, written and electronic across the organization. All authorized personnel within our organization who deal with your information are bound to confidentiality through a confidentiality agreement and are trained at least annually on corporate policies and procedures with respect to privacy and security.

Effective Date

The effective date of this notice is April 14, 2003, except with respect to modifications, which are effective as of September 23, 2013. Medical Mutual is required to follow the terms of this notice until it is replaced. Medical Mutual reserves the right to change this Notice at any time as allowed by law and will notify you of any changes as required by law. Medical Mutual reserves the right to make such changes apply to all information it maintains.

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

As a member of MedMutual Advantage PPO, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

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

For complaints regarding physicians, contact the Medical Board in the state in which your physician is located. If you need that phone number, Customer Care can assist you.

For complaints regarding hospital/health care facilities, contact the Department of Health in the state in which the hospital/health care facility is located. If you need that phone number, Customer Care can assist you.

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

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

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

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

- You can **call Customer Care**.
- You can **call the State Health Insurance Assistance Program (SHIP).** For details, go to Chapter 2, Section 3.
- You can contact **Medicare.**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

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

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

CHAPTER 7:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in Appendix 1 of this document.

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we 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 care before you receive it, you can ask us to make a coverage decision for you.

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at Customer Care**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at MedMutual.com/MAgroup.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

  - If you want a friend, relative, or another person to be your representative, call Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at MedMutual.com/MAgroup.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

If you're not sure which section you should be using, please call Customer Care. You can also get help or information from government organizations such as your State Health Insurance Assistance Program (SHIP).

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

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

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

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

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

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

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

- You may *only ask* for coverage for medical care, items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

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

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

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days.** If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a *fast complaint*. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.

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

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

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

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

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

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

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

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

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision. It is also called turning down your appeal.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

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

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

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

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

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

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

     You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
  - If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

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

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

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

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

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

What happens during this review?

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

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

- If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Customer Care or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Grievance process.** You or your representative may file your concerns in writing or verbally. Please follow the grievance process described below.

  When filing a grievance, please provide the following information:

  - Your name, address, telephone number where we can reach you if we have questions; your ID Number from your plan membership card; for written grievances, your or your authorized representative's signature and the date signed; a summary of the grievance and your description of any previous contact with us on the matter; and a description of the action you are requesting to resolve the grievance. If you or your authorized representative require assistance in preparing and submitting your written grievance, contact Customer Care at the number shown in Chapter 2 of this booklet.

  You may request an expedited (fast) grievance if:

  - You disagree with our decision to extend the timeframe to make an initial (standard) organization/coverage determination or reconsideration
  - We deny your request for a 72-hour/fast (expedited) organization/coverage determination or reconsiderations/redeterminations
  - We deny your request for a 72-hour/fast (expedited) appeal

  If you mail the request for an expedited grievance, we will provide oral acknowledgement upon receipt. We will make a determination within 24 hours of receipt of your request.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

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

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 9.5 You can also tell Medicare about your complaint

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

CHAPTER 8:

Ending your membership in the plan

Note: This chapter contains general information about disenrollment from a Medicare Advantage plan. For more information or for specific options available to you as a member of a group-sponsored plan, please contact your group benefits administrator.

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MedMutual Advantage PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

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

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

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

The enrollment time periods vary depending on your situation.

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

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

OR

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

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.2 Where can you get more information about when you can end your membership?

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

- Contact your group's benefits administrator or, if so directed by that administrator, Customer Care.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048.)

SECTION 3 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from MedMutual Advantage PPO when your new plan's coverage begins.
• Original Medicare with a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from MedMutual Advantage PPO when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. • You can also contact **Medicare,** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from MedMutual Advantage PPO when your coverage in Original Medicare begins.

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

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

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

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

SECTION 5 MedMutual Advantage PPO must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

MedMutual Advantage PPO must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call your group's benefit administrator, or if so directed by that administrator, Customer Care to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If your group's benefit administrator determines you are no longer eligible for the plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call **your group's benefit administrator, or if so directed by that administrator, Customer Care**.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

MedMutual Advantage PPO is not allowed to ask you to leave our plan for any health-related reason.

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

If your group's benefit administrator determines you are no longer eligible for the plan, you will need to contact your group's benefit administrator.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

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

Nondiscrimination in Health Programs and Activities

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.)
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
100 American Road
Cleveland, OH 44144-2322

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  http://www.hhs.gov/ocr/office/file/index.html.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, MedMutual Advantage PPO, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will be null and void.

SECTION 5 Waiver by Agents

No agent or other person, except an executive officer of Medical Mutual, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart in Chapter 4.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

SECTION 6 Consent to Release Medical Information

You consent to the release of medical information to Medical Mutual when you sign an application.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual. Medical Mutual has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

SECTION 7 Limitation of Actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than 3 years after the service upon which the legal action is based was provided.

SECTION 8 Plan's Sole Discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*. This applies if we determine such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

SECTION 9 Coordination of Benefits

As described in Chapter 1 (Section 7) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Medicare Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 10 Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition. The following apply:

You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.

The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and, pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.

If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

SECTION 11 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, our plan has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at our plan's discretion. You shall execute any documents and cooperate with us to secure our right to recover such overpayments, upon our request.

SECTION 12 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the patient's medical needs and condition;
  - Ordered and furnished by qualified personnel;
  - One that meets, but does not exceed, the patient's medical need; and
  - At least as beneficial as an existing and available medically appropriate alternative.

SECTION 13 Our contracting arrangements

We pay providers using various payment methods, including capitation, per diem, incentive and discounted fee-for-service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted fee-for-service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need.

SECTION 14 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions. In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

SECTION 15 Presidential or Governor Emergencies

In the event of a Presidential or Governor emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, we will make the following exceptions to assure adequate care during the emergency:

Approve services to be furnished at specified non-contracted facilities that are considered Medicare-certified facilities; and

Temporarily reduce cost sharing for plan-approved, out-of-network services to the in-network cost sharing amounts.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, we will resume normal operations 30 days from the initial declaration. When a disaster or emergency is declared, it is specific to a geographic location (i.e., county). We will apply the above exceptions only if you reside in the geographic location indicated.

CHAPTER 10:

Definitions of important words

Chapter 10. Definitions of important words

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

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

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

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

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

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

Combined Maximum Out-of-Pocket Amount - This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3, for information about your combined maximum out-of-pocket amount.

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

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

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

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

Covered Services - The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

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

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

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

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

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

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

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

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

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

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

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

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

Group Open Enrollment Period - The set time each year when members can change their group-sponsored health and/or drug plans offered by their employer or union group. This time is set each year by the group's benefit administrator and may change from year to year.

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

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

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

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

In-Network Maximum Out-of-Pocket Amount - The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

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. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

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

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

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

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

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

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

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

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

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

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

Out-of-Pocket Costs - See the definition for *cost sharing* above. A member's cost sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

PACE plan - A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C - See Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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

Prior Authorization - Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets *prior authorization* from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

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

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

Rehabilitation Services - These services include physical therapy, speech and language therapy, and occupational therapy.

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

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

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

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

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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.

Urgently Needed Services - Covered services that are not emergency services provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

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

APPENDIX 1 State Health Insurance Assistance Programs (SHIPs)

State Health Insurance Assistance Programs (SHIPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

State	Address/Website	Phone
Alabama	State Health Insurance Assistance Program (SHIP) Alabama Department of Senior Services 201 Monroe St., Suite 350 Montgomery, AL 36104 www.alabamaageline.gov/ship/	1-800-243-5463
Alaska	State Health Insurance Assistance Program (SHIP) Alaska Medicare Information Office 1835 Bragaw Street, Suite 350 Anchorage, AK 99508 http://hss.medicare@aalaska.gov	1-800-478-6065 TTY: 1-800-770-8973
Arizona	State Health Insurance Assistance Program (SHIP) Individuals should contact the SHIP office in the county in which they reside. https://des.az.gov//medicare-assistance	1-800-432-4040
Arkansas	Senior Health Insurance Information Program Arkansas Insurance Department One Commerce Way Little Rock, AR 72202 https://www.shiipar.com	1-800-224-6330
California	State Health Insurance Assistance Program (SHIP) California Health Insurance Counseling and Advocacy Program (HICAP) 2880 Gateway Oaks Drive, Suite 200 Sacramento, CA 95833 https://www.aging.ca.gov/hicap/	1-800-434-0222
Colorado	Senior Health Insurance Assistance Program (SHIP) Division of Insurance Colorado Department of Regulatory Agencies 1560 Broadway, Suite 850 Denver, CO 80202 https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	1-888-696-7213
Connecticut	The CHOICES Program https://portal.ct.gov/ADS-CHOICES	1-800-994-9422
Delaware	Delaware Medicare Assistance Bureau (DMAB) DMAB@delaware.gov https:/insurance.delaware.gov/dmab	1-800-336-9500 Local 302-674-7364
District of Columbia	Health Insurance Counseling Project (HICP) 500 K St., NE Washington, D.C. 20002 https://dcoa.dc.gov/service/dc-state-health-insurance-assistance-program-ship	1-202-727-8370 TTY:711

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Florida	Serving Health Insurance Needs of Elders (SHINE) Program Florida Department of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399-7000 https://www.floridashine.org/	1-800-963-5337 TTY: 1-800-955-8770
Georgia	Georgia SHIP Georgia Department of Human Services' (DHS) Division of Aging Services (DAS) State Health Insurance Assistance Program 47 Trinity Ave. S.W. Atlanta, GA. 30334 https://aging.georgia.gov/georgia-ship	1-866-552-4464 (Option #4) Monday through Friday, 8 a.m. – 5 p.m.
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) Executive Office on Aging – No. 1 Capitol District 250 South Hotel St., Suite 406 Honolulu, HI 96813-2831 https://www.hawaiiship.org/	1-808-586-7299 Toll Free 1-888-875-9229
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) – Idaho Department of Insurance 700 West State St., 3rd Floor P.O. Box 83720 Boise, ID 83720-0043 https://www.shiba.idaho.gov	1-800-247-4422 Monday through Friday, 8 a.m. to 5 p.m.
Illinois	Senior Health Insurance Program (SHIP) One Natural Resources Way, #100 Springfield, IL. 62702-1271 https://www2.illinois.gov/aging/ship	1-800-252-8966 TTY: 1-888-206-1327
Indiana	State Health Insurance Assistance Program (SHIP) 311 W. Washington St. Indianapolis, IN 46204 https://www.in.gov/ship	1-800-452-4800
Iowa	Senior Health Insurance Information Program SHIIP-SMP https://shiip.iowa.gov	1-800-351-4664 TTY: 1-800-735-2942
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) Kansas Department for Aging and Disability Services New England Building 503 South Kansas Ave. Topeka, KS 66603-3404 https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	1-800-860-5260

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Kentucky	State Health Insurance Assistance Program (SHIP) Kentucky Cabinet for Health and Family Services Department for Aging and Independent Living Office of the Secretary 275 East Main St., 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 (Option #2)
Louisiana	Senior Health Insurance Information Program (SHIIP) 1702 N. Third St. P.O. Box 94214 Baton Rouge, LA 70802 https://www.ldi.la.gov/consumers/senior-health-shiip	1-800-259-5300
Maine	Maine State Health Insurance Assistance Program (SHIP) Maine Department of Health and Human Services 109 Capital Street 11 State House Station Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-800-262-2232 (SHIP) 1-877-353-3771 (ADRC)
Maryland	State Health Insurance Assistance Program (SHIP) Maryland Department of Aging 301 West Preston St., Suite 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425
Massachusetts	Serving Health Information Needs of Elders (SHINE) https://www.mass.gov/health-insurance-counseling	1-800-243-4636 TTY/ASCII (800) 439-2370
Michigan	Michigan Medicare Assistance Program (MMAP, Inc.) https://www.mmapinc.org	1-800-803-7174
Minnesota	Minnesota Senior LinkAge Line 540 Cedar St. St. Paul, MN 55164 https://mn.gov/senior-linkage-line/	1-800-333-2433
Mississippi	State Health Insurance Assistance Program (SHIP) Mississippi Department of Human Services Division of Aging & Adult Services 200 S. Lamar St. Jackson, MS 39201 https://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program	1-844-822-4622 (SHIP) 1-601-359-4500
Missouri	Missouri SHIP, State Health Insurance Assistance Program (SHIP) https://www.missouriship.org	1-800-390-3330

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Montana	Montana State Health Insurance Assistance Program (SHIP) https://dphhs.mt.gov/sltc/aging/SHIP	1- 800-551-3191
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP) Nebraska Department of Insurance 2717 S. 8th St., Suite 4 Lincoln, NE 68508 https://doi.nebraska.gov/ship	1-800-234-7119
Nevada	Nevada Medicare Assistance Program (MAP) 3208 Goni Rd., Suite 181 Carson City, NV 89706 https://www.nevedacareconnection.org/care-options/types-of-services/healthcare/medicare-assistance-program-map/	1-800-307-4444
New Hampshire	New Hampshire State Health Insurance Assistance Program (SHIP) https://www.dhhs.nh.gov	1-866-634-9412
New Jersey	State Health Insurance Assistance Program (SHIP) New Jersey Department of Human Services Division of Aging Services https://www.state.nj.us/humanservices/doas/services/ship/	1-800-792-8820
New Mexico	New Mexico ADRC – State Health Insurance Assistance Program (SHIP) New Mexico Aging & Long-Term Services Dept. 2550 Cerrillos Road Santa Fe, NM 87505 https://www.nmaging.state.nm.us/	1-800-432-2080 TTY: 1-505-476-4937
New York	Health Insurance Information Counseling and Assistance Program (HIICAP) https://aging.ny.gov/health-insurance-information-counseling-and-assistance	1-800-701-0501
North Carolina	Seniors' Health Insurance Information Program (SHIIP) North Carolina Department of Insurance Albemarle Building 325 N. Salisbury Street Raleigh, NC 27603 https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip.	1-855-408-1212
North Dakota	State Health Insurance Counseling Program (SHIC) 600 E. Boulevard Ave. Bismarck, ND 58505 https://www.insurance.nd.gov/shic-medicare	1-888-575-6611

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) Ohio Department of Insurance 50 West Town St., 3rd Floor, Suite 300 Columbus, OH 43215 https://insurance.ohio.gov/about-us/divisions/oshiip	1-800-686-1578 Monday through Friday, 7:30 a.m. – 5 p.m.
Oklahoma	Senior Health Insurance Counseling Program (SHIP) Oklahoma Insurance Department 400 NE 50th St. Oklahoma City, OK 73105 https://www.oid.ok.gov	1-800-763-2828
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) https://shiba.oregon.gov	1-800-722-4134
Pennsylvania	Pennsylvania Medicare Education and Decision Insight – PA MEDI http://www.aging.pa.gov	1-800-783-7067 8 a.m. to 5 p.m. Monday-Friday
Puerto-Rico	State Health Insurance Assistance Program SHIP https://agencias.pr.gov/ship	1-877-725-4300 TTY: 787-919-7291
Rhode Island	Rhode Island State Health Insurance Assistance Program (SHIP) Rhode Island Department of Human Services Office of Healthy Aging 25 Howard Ave. Building 57 Cranston, RI 02920 https://oha.ri.gov/medicare	1-888-884-8721 TTY: 1-401-462-0740
South Carolina	State Health Insurance Assistance Program (SHIP) 1301 Gervais St., Suite 350 Columbia, SC 29201 https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid-	1-800-868-9095
South Dakota	Senior Health Information and Insurance Education (SHIINE) https://www.shiine.net	Eastern South Dakota: 1-800-536-8197 Central South Dakota: 1-877-331-4834 Western South Dakota: 1-877-286-9072
Tennessee	Tennessee State Health Insurance Assistance Program (SHIP) https://tn.gov/aging/ship	1-877-801-0044

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Texas	Health Information Counseling and Advocacy Program (HICAP) – Texas Department of Aging and Disability https://www.hhs.texas.gov/services/health/medicare	1-800-252-9240
US Virgin Islands	The Virgin Islands State Health Insurance Assistance Program (VI SHIP) https://ltg.gov.vi/departments/vi-ship-medicare	1-340-773-6459 x3105 (St. Croix) 1-340-774-7166 x4510 (St. Thomas/St. John)
Utah	Senior Health Insurance Information Program (SHIP) Aging and Adult Services of Utah https://daas.utah.gov/seniors/	1-800-541-7735
Vermont	State Health Insurance Assistance Program (SHIP) Vermont Association for Area Agencies on Aging https://asd.vermont.gov.	1-800-642-5119 802-241-0294
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) Virginia Division for the Aging 1610 Forest Ave., Suite 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402
Washington	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commissioner https://www.insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/	1-800-562-6900 TTY: 1-360-586-0241 8 a.m. to 5 p.m. Monday-Friday
West Virginia	West Virginia State Health Insurance Assistance Program (WV SHIP) West Virginia Bureau of Senior Services 1900 Kanawha Boulevard East Town Center Mall, 3rd Level Charleston, WV 25305 https://www.wvship.org	1-877-987-4463 304-558-3317
Wisconsin	State Health Insurance Assistance Program (SHIP) https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	1-800-242-1060
Wyoming	Wyoming State Health Insurance Information Program (WSHIIP) http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	1-800-856-4398

APPENDIX 2 Medicaid Agencies

State Medicaid Offices
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

State	Address/Website	Phone
Alabama	Alabama Medicaid 501 Dexter Avenue Montgomery, AL 36104 https://medicaid.alabama.gov	1-800-362-1504
Alaska	Alaska Medicaid Office 3601 C Street, Suite 902 Anchorage, AK 99503 https://health.alaska.gov	1-800-780-9972
Arizona	Arizona Health Care Cost Containment 801 East Jefferson Street Phoenix, AZ 85034 https://www.azahcccs.gov	800-523-0231 In-State Toll Free: 800-654-8713 (Outside Maricopa County) In-State Toll Free: 602-417-4000 (Inside Maricopa County)
Arkansas	Arkansas Department of Human Services Donaghey Plaza South P.O. Box 1437 Little Rock, AR 72203 https://humanservices.arkansas.gov	800-482-5431 501-682-8233
California	California Medicaid Management Information Systems Operations Medi-Cal Department of Health Care Services P.O. Box 942732 Sacramento, CA 94234 https://medi-cal.ca.gov	800-541-5555
Colorado	Colorado Department of Health Care Policy and Financing Health First Colorado 1570 Grant Street Denver, CO 80203-1818 https://hcpf.colorado.gov	1-800-221-3943
Connecticut	Connecticut Department of Social Services HUSKY Health Program 55 Farmington Avenue Hartford, CT 06105 https://portal.ct.gov/HUSKY	1-877-874-1612

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Delaware	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 North DuPont Highway, Lewis Building P.O. Box 906 New Castle, DE 19720 https://dhss.delaware.gov/dhss	1-800-223-9704
District of Columbia	DC Department of Health Care Finance 441 4th Street, NW, 900S Washington, DC 20001 https://dhcf.dc.gov/service/medicaid	Local: 1-202-442-5988
Florida	Florida Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL. 32308 https://www.myflfamilies.com/service-programs/access/medicaid	1-850-300-4323
Georgia	Georgia Department of Community Health 2 Martin Luther King, Jr. Drive, SE, East Tower Atlanta, GA 30303 https://dch.georgia.gov/	1-404-656-4507
Hawaii	Department of Human Services https://medquest.hawaii.gov/	1-800-316-8005
Idaho	Idaho Department of Health and Welfare https://idalink.idaho.gov	1-877-456-1233
Illinois	Illinois Department of Healthcare and Family Services ABE Application for Benefits Eligibility https://abe.illinois.gov	800-843-6154
Indiana	Indiana Family and Social Services Administration FSSA Document Center 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46207 https://www.in.gov/fssa/da/	800-403-0864
Iowa	Iowa Medicaid Enterprise Department of Human Services – Member Services https://IAHealthLink.gov	1-800-338-8366 TTY 800-735-2942
Idaho	Idaho Department of Health and Welfare Idaho Medicaid Health Plan – The Enhanced Plan 450 West State Street Boise, ID 83720 https://healthandwelfare.idaho.gov	1-877-456-1233 TTY/TDD 888-791-3004
Kansas	KanCare https://www.kdhe.ks.gov/	1-800-792-4884 TTY 800-792-4292

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Kentucky	Department for Medicaid Services Cabinet for Health and Family Services Office of the Secretary 275 East Main Street Frankfort, KY 40621 https://kynect.ky.gov/	855-459-6328
Louisiana	Louisiana Department of Health 628 N. 4th Street Baton Rouge, LA 70821-0629 https://ldh.la.gov/ subhome/1	1-888-342-6207
Maine	Office of MaineCare Services 109 Capitol St. 11 State House Station Augusta, ME 04333 https://www.maine.gov/dhhs	1-800-977-6740 1-207-287-3707
Maryland	Maryland Health Connection https://marylandhealthconnection.gov	1-855-642-8572
Massachusetts	Massachusetts Office of Health and Human Services MassHealth One Ashburton Place Boston, MA 02108 https://www.mass.gov/masshealth	1-800-841-2900
Michigan	Michigan Department of Health & Human Services (MDHHS) MI Bridges https://www.michigan.gov/mdhhs/assistance-programs/medicaid	1-800-975-7630
Minnesota	Department of Human Services Health Care Eligibility and Access Division Senior LinkAge Line https://mn.gov/dhs/people-we-serve/seniors	1-800-333-2433
Mississippi	Mississippi Division of Medicaid 550 High Street, Suite 1000 Jackson, MS 39201 https://www.medicaid.ms.gov	1-800-421-2408
Missouri	Missouri Department of Social Services/ MO HealthNet Division https://dss.mo.gov/healthcare	1-855-373-9994
Montana	Department of Public Health and Human Services Health Resources Division https://dphhs.mt.gov/MontanaHealthcarePrograms	1-888-706-1535
Nebraska	Department of Health and Human Services 301 Centennial Mall South Lincoln, NE 68509 https://dhhs.ne.gov	1-855-632-7633 402-471-3121

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Nevada	Department of Health and Human Services Division of Health Care Financing and Policy https://www.medicaid.nv.gov/providers/enrollees/nvmedicaid	1-800-992-0900 775-684-3676
New Hampshire	New Hampshire Department of Health & Human Services DHHS https://nheasy.nh.gov	1-844-275-3447-Option 8 TTY 1-800-735-2964
New Jersey	NJ Department of Human Services Aging and Disability Resource Connection NJ Medicaid P.O. Box 715 Trenton, NJ 08625 https://www.adrcnj.org	1-800-792-9745 1-800-701-0710
New Mexico	Human Services Department Centennial Care https://www.hsd.state.nm.us/lookingforassistance/centennial-care-overview/	1-800-283-4465
New York	New York State Department of Health https://www.health.ny.gov/health_care/medicaid/	1-800-505-5678
North Carolina	North Carolina Department of Health and Human Services NC Medicaid Division of Health Benefits https://medicaid.ncdhhs.gov	1-888-245-0179
North Dakota	Department of Human Services Medical Services Division 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250 https://www.hhs.nd.gov/healthcare/medicaid-expansion	1-800-755-2604
Ohio	Ohio Department of Medicaid 50 West Town Street, Suite 400 Columbus, Ohio 43215 https://medicaid.ohio.gov	1-800-324-8680
Oklahoma	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 https://oklahoma.gov/ohca.html	1-800-987-7767 Local: 1-405-522-7300
Oregon	Oregon Health Plan (OHP) Health Systems Division 500 Summer Street, NE, E15 Salem, OR 97301 https://www.oregon.gov/odhs	800-699-9075
Pennsylvania	Pennsylvania Department of Aging https://www.aging.pa.gov	1-800-753-8827

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Puerto Rico	Programa Medicaid Departamento de Salud P.O. Box 70184 San Juan, PR 00936-8184 https://www.medicaid.pr.gov/Medicaid	787-641-4224
Rhode Island	RI Executive Office of Health and Human Services HealthSourceRI Walk-in Center 401 Wampanoag Trail East Providence, RI 02915 https://healthyrhode.ri.gov	1-855-840-4774
South Carolina	Department of Health and Human Services Healthy Connections Medicaid P.O. Box 8206 Columbia, SC 29202-8206 https://www.scdhhs.gov	1-888-549-0820 TTY 1-888-842-3620
South Dakota	Department of Social Services 700 Governors Dr. Pierre, SD 57501 https://dss.sd.gov/medicaid	1-800-597-1603 Local: 605-773-3165
Tennessee	TennCare 310 Great Circle Road Nashville, TN 37243 https://tenncareconnect.tn.gov	1-855-259-0701
Texas	Texas Health and Human Services https://hhs.texas.gov/services/health/medicaid-chip	800-252-9240
Utah	Utah Department of Health Medicaid 194 North 1950 West Salt Lake City, UT 84116 https://medicaid.utah.gov/	1-866-435-7414
Vermont	Department of Vermont Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671 https://dvha.vermont.gov/department-vermont-health-access-	1-800-250-8427 1-802-879-5900
Virginia	Department of Medical Assistance Services-Cover Virginia 600 East Broad Street Richmond, VA 23219 https://www.dmas.virginia.gov/	1-855-242-8282 TTY 1-888-221-1590
Washington	Washington State Department of Social and Health Services https://www.dshs.wa.gov/esa/community-services-offices/medicare-savings-program	1-877-501-2233

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
West Virginia	Department of Health and Human Resources Bureau for Medical Services 350 Capitol Street, Room 251 Charleston, WV 25301 https://www.dhhr.wv.gov	1-877-716-1212 304-558-1700
Wisconsin	Department of Health Services 1 West Wilson Street Madison, WI 53703 https://www.dhs.wisconsin.gov	1-800-947-3529 1-608-266-1865
Wyoming	Wyoming Department of Health 122 W. 25th St. 4th Floor Cheyenne, WY 82002 https://www.health.wyo.gov	1-855-294-2127 1-307-777-7531

Multi-Language Interpreter Services

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

MedMutual Advantage PPO Plan Customer Care

Method	Customer Care - Contact Information
CALL	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
WRITE	Medical Mutual Attn: Customer Care P.O. Box 94563 Cleveland, OH 44101-4563
WEBSITE	MedMutual.com/MAgroup

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. See Appendix 1 to find the SHIP for your state.