2023 Evidence of Coverage MediGold Mount Carmel Cash Back No Premium MA Only (HMO)
(serving Central, Southwest, and Northwest Ohio)

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

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of MediGold Mount Carmel Cash Back No Premium MA Only (HMO)

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

For questions about this document, please contact Member Services at 1-800-240-3851 for additional information. (TTY users should call 711.) Hours are 8 a.m. – 8 p.m., 7 days a week. On certain holidays, your call will be handled by our automated phone system.

This plan, MediGold Mount Carmel Cash Back No Premium MA Only (HMO), is offered by Mount Carmel Health Plan, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Mount Carmel Health Plan, Inc. When it says "plan" or "our plan," it means MediGold Mount Carmel Cash Back No Premium MA Only (HMO).)

This document may be available in an alternate format such as braille, large print or audio. Please call Member Services at the number printed on the back cover of this booklet for assistance with an alternate format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024.

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.

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2023 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in MediGold Mount Carmel Cash Back No Premium MA Only (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, MediGold Mount Carmel Cash Back No Premium MA Only (HMO). 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.

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. MediGold Mount Carmel Cash Back No Premium MA Only (HMO) does not include Part D prescription drug coverage.

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

Section 1.2 What is the *Evidence of Coverage* 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO).

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 our plan's Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO)between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of MediGold Mount Carmel Cash Back No Premium MA Only (HMO) after December 31, 2023. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services) must approve MediGold Mount Carmel Cash Back No Premium MA Only (HMO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area) Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for MediGold Mount Carmel Cash Back No Premium MA Only (HMO)

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 plan service area includes these counties in Ohio: Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Coshocton, Crawford, Darke, Defiance, Delaware, Fairfield, Fayette, Franklin, Fulton, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Jackson, Knox, Licking, Logan, Lucas, Madison, Miami, Monroe, Montgomery, Morgan, Morrow, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Preble, Putnam, Ross, Seneca, Shelby, Union, Vinton, Warren, Washington, Wood and Wyandot.

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

have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.3 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) if you are not eligible to remain a member on this basis. MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 Member Services right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our 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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which MediGold Mount Carmel Cash Back No Premium MA Only (HMO) authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at (MediGold.com).

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services.

SECTION 4 Your monthly costs for MediGold Mount Carmel Cash Back No Premium MA Only (HMO)

Your costs may include the following:

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

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called "2023 Medicare Costs." If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for *MediGold Mount Carmel Cash Back No Premium MA Only (HMO)*.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

While you are enrolled in this plan, we will pay up to $50 of your Medicare Part B premium. You are required to continue paying your Medicare Part B premium to Medicare in order to stay enrolled in this plan. If your Medicare Part B premium is automatically deducted from your monthly Social Security check, you will see an increase of up to $50 in your monthly Social Security check. If your Medicare Part B premium is paid directly to Medicare, you will see a reduction of up to $50 in the monthly amount you owe to Medicare.

Upon enrollment in this plan, it can take one to three months for the Social Security Administration and Medicare to complete the processing of your Medicare Part B premium reduction. However, any missed months during the processing phase will be recouped by the member through a lump sum adjustment to your check from the Social Security Administration, or applied to the amount you owe directly to Medicare. From that point forward, the applicable amount will be applied on a monthly basis.

Likewise, if you disenroll from this plan, it can take one to three months for the Social Security Administration and Medicare to terminate your Medicare Part B premium reduction. Any reductions applied after the date of disenrollment will be charged back to the member through a lump sum adjustment to your check from the Social Security Administration, or applied to the amount you owe directly to Medicare.

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 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits," then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

The premium for the Optional Supplemental Dental Silver benefit is $16 per month. The premium for the Optional Supplemental Dental Gold benefit is $34 per month. You pay this monthly premium in addition to your Medicare Part B premium.

Your premium for "optional supplemental benefits" is due every month as long as you are enrolled in the optional supplemental plan. Any additional amount paid will be carried forward as a credit and applied to future month(s) premium(s) or payments(s). Generally, the plan will *only* issue a premium or payment refund if you are disenrolled from the optional supplemental plan, either voluntarily or upon death, prior to the 1st day of any month for which we have received payment. Partial month premium amounts or payments will not be refunded. Refund checks will only be made payable to the member or the member's estate.

Section 4.4 Can we change your monthly plan premium during the year?

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

SECTION 5 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 including your Primary Care Provider.

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

Let us know about these changes:

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

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

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

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 Member Services. 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 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) contacts
(how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to MediGold Mount Carmel Cash Back No Premium MA Only (HMO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-800-240-3851 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week
FAX	1-833-256-2871
WRITE	MediGold Attn: Member Services 3100 Easton Square Place Third Floor – Health Plan Columbus, Ohio 43219
WEBSITE	MediGold.com

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	1-800-240-3851 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week
TTY	711 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week
FAX	Coverage Decisions: 1-800-991-9907 Appeals: 1-833-802-2495
WRITE	MediGold Attn: Health Services (Coverage Decisions) or Attn: Appeals (Appeals) 3100 Easton Square Place Third Floor – Health Plan Columbus, Ohio 43219
WEBSITE	MediGold.com

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	1-800-240-3851 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week
TTY	711 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week
FAX	1-833-802-2495
WRITE	MediGold Attn: Appeals and Grievances Coordinator 3100 Easton Square Place Third Floor – Health Plan Columbus, Ohio 43219
MEDICARE WEBSITE	You can submit a complaint about MediGold Mount Carmel Cash Back No Premium MA Only (HMO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information
CALL	1-800-240-3851 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week.
TTY	711 Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week.
FAX	1-833-256-2871
WRITE	MediGold Attn: Member Services 3100 Easton Square Place Third Floor – Health Plan Columbus, Ohio 43219
WEBSITE	MediGold.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) • **Tell Medicare about your complaint:** You can submit a complaint about MediGold Mount Carmel Cash Back No Premium MA Only (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website 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. In Ohio, the SHIP is called Ohio Senior Health Insurance Information Program.

Ohio Senior Health Insurance Information Program 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.

Ohio Senior Health Insurance Information Program 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. Ohio Senior Health Insurance Information Program counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	Ohio Senior Health Insurance Information Program - Contact Information
CALL	1-800-686-1578
WRITE	Ohio Department of Insurance 50 West Town Street Third Floor – Suite 300 Columbus, Ohio 43215
WEBSITE	insurance.ohio.gov/about-us/divisions/oshiip

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Ohio the Quality Improvement Organization is called Livanta.

Livanta 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. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

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

Method	Livanta LLC - Contact Information
CALL	1-888-524-9900 Helpline representatives are available 9 a.m. – 5 p.m., Monday through Friday, 11 a.m. – 3 p.m., Saturday and Sunday; 24-hour voicemail service is available.
TTY	1-888-985-8775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-833-868-4059
WRITE	Livanta LLC BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

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

getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 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 the Ohio Department of Medicaid.

Method	Ohio Department of Medicaid – Contact Information
CALL	1-800-324-8680
WRITE	Ohio Department of Medicaid 50 West Town Street, Suite 400 Columbus, Ohio 43215
WEBSITE	www.medicaid.ohio.gov

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

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are "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, MediGold Mount Carmel Cash Back No Premium MA Only (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- Referrals from your PCP are not required when seeking covered services from network providers.

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
  - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. However, you or your provider must get prior authorization (approval) by the plan for the out-of-network care before seeking non-emergency or non-urgent care out-of-network. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

A Primary Care Provider, also known as a PCP, is a doctor or other medical professional who commonly provides all basic and routine medical care for you. S/He is generally most familiar with your medical condition and history. PCPs are professionally trained and licensed by the state. Commonly, they are Family and General Practitioners, Internal Medicine Practitioners, Geriatric Practitioners or other professionally trained medical providers.

Although you must select a network PCP when you first join MediGold, you DO NOT need a referral from him or her before seeking care from your other in-network providers. You may visit any network provider for covered services. However, your PCP is often the best person to help you find a specialist or other provider to meet your needs. Ask your PCP to help you; s/he is happy to do so.

Your PCP can also help coordinate other services on your behalf, such as:

- X-rays.
- Laboratory tests.
- Therapies.
- Hospital admissions.
- Follow-up care when needed.

Your PCP will stay in touch with other providers involved with your care, such as consultants or specialists. If you need other services or supplies, ask your PCP to help. S/He can also help you obtain prior authorization for supplies and services if prior authorization is needed.

How do you choose your PCP?

You may select your PCP by using the MediGold *Provider Directory* or by getting help from Member Services. You can also access a list of PCPs online at MediGold.com/Find-a-Provider.

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.

To change your PCP, simply call Member Services. A representative will adjust your membership record to reflect your newly selected PCP. Your PCP change will take effect the first day of the following month after your request is received. Remember to have your prior medical records sent to your new PCP before your first appointment.

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 from your PCP to seek covered care from network providers, including specialists. However, there are specific services that require prior authorization regardless of the provider you use. For a list of services that require prior authorization, refer to Chapter 4, Section 2.1.

Network providers will request prior authorization on your behalf when needed. You and out-of-network providers may also request prior authorization when needed (see *How to contact us when you are asking for a coverage decision about your medical care* in Chapter 2). When MediGold approves a supply or service that requires prior authorization, the approval will specify what service has been approved, who can provide it and any limitations that may apply. If a prior authorization request is denied, you or the requesting provider may ask for an appeal (see Chapter 9, Section 5 for more information about filing an appeal). If you have questions about a particular approval notice (or denial), please call the Prior Authorization number on the back of your MediGold ID card.

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 make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior Authorization is needed for services from an out-of-network provider. Please refer to Chapter 7, Section 5 for further information about requesting coverage from an out-of-network provider
- 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.

When a specialist or other network provider leaves our plan, we make our best effort to keep members advised. For instance, you will find the most updated listing of providers online at MediGold.com/Find-A-Provider. Please check this online directory before seeking care from a doctor or other provider who is new to you. If your PCP leaves our network, you will be sent a letter of notification so you may choose another PCP from our network. We make every reasonable effort to keep you informed of such changes.

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

Generally speaking, you must use network providers to receive covered care. However, there are two (2) exceptions:

- MediGold provides benefits for use of out-of-network providers for emergency care provided in a hospital emergency room worldwide, urgently needed services as are commonly provided in an urgent care center worldwide, and out-of-area renal dialysis received from any Medicare-certified dialysis provider throughout the U.S. (See Section 3 of this chapter for more information.)
- If you are in need of specialized care that is not available within the plan's provider network (when such care is prior authorized in advance by the plan).

We encourage you to work through your PCP or network specialist when making requests for prior authorization for out-of-network care. Your doctor can best explain your medical condition and provide any rationale needed regarding your request. All requests for prior authorization are given full and fair consideration. Approved authorizations however, are not a guarantee of claims payment.

Requests for prior authorization are handled through the plan's Health Services Department. You may contact them by calling the number shown in Chapter 2, Section 1, *How to contact us when you are asking for a coverage decision about your medical care*. The prior authorization number is also located on the back of your MediGold ID card. Requests should include clinical facts, supporting documentation and any other rationale for out-of-network care.

Your doctor may call 1-800-991-9907 to receive instructions on the plan's prior authorization process, related form(s) and handling.

When requests are received, the plan will promptly make a determination regarding the request. The plan will then alert the requestor of its determination (approved or denied). MediGold follows CMS timeframes, which allows us up to 14 days to render a decision, but if all necessary information is submitted by your provider, we will respond promptly. In some cases, you or the plan can ask for an additional 14 days to further research facts related to the request or to obtain more information, when doing so may benefit the member. If we decide to take the extra days, we will tell you in writing. If your medical condition or situation requires expedited handling of a request, you or your doctor may request an expedited review. For details related to what qualifies for an expedited request, please refer to Chapter 7, Section 5.2 of this document. If an expedited review is warranted, determinations related to your request will be made within 72 hours. If your request is approved, we will notify the requesting doctor of the approval and give details as to what services were approved and where they can be performed. If your prior authorization request is denied, you will be sent a letter stating why the request was denied and be provided your rights for filing an appeal as noted in Chapter 7, Section 5.

If you have questions regarding prior authorization, its processes or wish to make a request yourself, please call Member Services at the number listed on the back cover of this document.

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 world-wide.
- **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. You may contact Member Services (the number is located on the back of your MediGold ID card), or call your PCP's office.

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.

What if it wasn't a medical emergency?

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

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

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

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

What are "urgently needed services"?

An "urgently needed service" is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by out of-network providers when it is unreasonable, given your circumstances, to obtain immediate care from network providers.

If you have an urgent need for services as described above and find that participating providers are not reasonably accessible, you may access urgently needed services from any Medicare-approved urgent care center. Urgent care centers are not generally associated with a hospital's emergency room (although they may be). Whether traveling or at home, contact Member Services if you need help locating an urgent care provider or advice on how to cost-effectively use your urgent care benefits.

Our plan covers urgently needed services or any other emergency care worldwide.

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:

www.medicare.gov/what-medicare-covers/getting-care-and-drugs-in-disasters-or-emergencies 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

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. If you reach the benefit limit, the amount you pay will not count toward your annual out-of-pocket maximum.

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.

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. 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, 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.

MediGold inpatient hospital benefits apply. See Chapter 4, Section 2.1 for more information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of MediGold Mount Carmel Cash Back No Premium MA Only (HMO), 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 member services for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments in 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 in 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO). 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:

- A **"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 the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is $3,900.

The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a double asterisk (**) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,900, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of MediGold Mount Carmel Cash Back No Premium MA Only (HMO), an important protection for you is that 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services.)
- If you believe a provider has "balance billed" you, call Member Services.

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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.

- You have a primary care provider (a PCP) who is providing and overseeing your care.

- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. In addition, the following services not listed in the Benefits Chart require prior authorization:

Air Mileage – Fixed Wing (FW) (per statute mile)
Air Mileage – Rotary Wing (RW) (per statute mile)
Non-Emergent - Air Service, Transport, One-Way, Fixed Wing (FW)
Non-Emergent - Air Service, Transport, One-Way, Rotary Wing (RW)
Chiropractic Services – you or your provider must get an approval from the plan before the plan will pay for services exceeding the Medicare benefit limits.
Diabetic Supplies and Services – you or your provider must get an approval from the plan before the plan will pay for supplies or services exceeding the Medicare benefit limits.
Durable medical equipment (DME) and related supplies – you or your provider must get an approval from the plan before MediGold will pay for equipment or supplies greater than the Medicare-allowable amount.
Genetic Testing
Hospital Admissions (Medical, Surgical, Behavioral Health and Rehabilitation)
Non-Medicare-covered Acupuncture - required for visits exceeding the annual visit limitation.
Oncology – Treatment Plans and Related Drugs
Out-of-Network Care (for HMO plan members)
Outpatient Services – Select Behavioral Health Services
Power Mobility Devices
Prosthetic devices and related supplies – you or your provider must get an approval from the plan before MediGold will pay for devices or supplies greater than the Medicare-allowable amount.
Radiation – Brachytherapy
Radiation – High Energy Neutron Radiation Treatment
Radiation – Intensity-Modulated Radiation Therapy
Radiation – Proton Beam Therapy
Radiation – Proton Therapy
Radiation – Stereotactic Radiosurgery
Radiation – Therapy (other)
Skilled Nursing Facility (SNF) Care
Surgery – Bariatric Surgery
Treatment – Hyperbaric Oxygen Chamber

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- 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 2023, 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
24-Hour Nurse Line Access to reliable care day or night. A toll-free dedicated number will connect members to a nurse who can: • Assess symptoms and triage. • Provide urgent and non-urgent care advice. • Provide referrals to programs, providers and facilities. • Provide medication information. • Provide decision support for diagnoses and condition explanations. When necessary, the nurse can connect members to a virtual care visit with a physician via telephone or video. To access care via the nurse line, call 1-855-638-5842	You pay a $0 copay for 24-hour nurse advice.
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 orders it.	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, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	$20 copay

Services that are covered for you	**What you must pay** when you get these services
Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: o 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, o 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. To find an acupuncturist in the plan's network, please visit MediGold.com/Find-a-Provider.	
Ambulance services* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$200 copay per ground ambulance transport (no additional copay for a round trip if the round trip is provided within the same calendar day by the same provider). $250 copay per air ambulance transport. Ambulance coverage excludes transportation by wheelchair

Services that are covered for you	**What you must pay** when you get these services
*Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	van, ambulette and trips to or from a physician's office.
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. **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.	There is no coinsurance, copayment, or deductible for the annual wellness visit. If lab, diagnostic or therapeutic services are provided during the same visit, a copay or coinsurance may apply.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, 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	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.	$30 copay per visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy

Services that are covered for you	**What you must pay** when you get these services
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.	cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years (60 months).
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	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services* Covered services include: • We cover only Manual manipulation of the spine to correct subluxation (see Chiropractic services exclusions in Chapter 4, Section 3.1). *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	$20 copay per visit.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA Based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover:	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. There is no outpatient surgery or ambulatory surgical center copay for a screening exam of the colon when it includes a biopsy or removal of any growth during the procedure if you get these services from a network provider. Refer also to the

Services that are covered for you	**What you must pay** when you get these services
• Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**Outpatient Surgery** section within this benefit chart (Chapter 4, Section 2.1).
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: • 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). In addition, we offer Preventive and Comprehensive Dental services. Covered dental services include: • Oral exam.** • Prophylaxis cleaning.** • X-ray/bitewing radiograph.** • Full mouth X-ray.** • Comprehensive diagnostic services.** • Restorative services.** • Extractions.** • Endodontics.** • Periodontics.** For more information or assistance finding a dental plan network provider near you, call MediGold Dental at 1-866-209-3212 (TTY 711), 8 a.m. - 8 p.m., Monday - Friday. **Important:** HMO members who have the preventive and comprehensive dental, as well as those who purchase the additional Optional Supplemental Dental benefit, must receive dental care from a MediGold Dental network provider for dental services to be covered. Dental benefits are administered by Dental Benefit Providers.	$30 copay for non-routine dental services. **Preventive Dental:** $0 copay oral exam (two per calendar year)** $0 copay for prophylaxis cleaning (two per calendar year)** $0 copay X-ray/bitewing radiograph (one per calendar year)** $0 copay full mouth X-ray, which includes bitewings (once in any three-year period)** **Comprehensive Dental:** $0 copay diagnostic services.** 50% coinsurance restorative services.** 50% coinsurance extractions.** 70% coinsurance endodontics.** 70% coinsurance periodontics.** There is a $1,000 annual combined benefit maximum.** **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4,

Services that are covered for you	**What you must pay** when you get these services
	Section 1.2 for more information.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, 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 meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, 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
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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	$0 copay for diabetes self-monitoring equipment and supplies when obtained in-network. Refer to the *Provider Directory* for a complete list of diabetic supply providers in the plan's network. 20% coinsurance for therapeutic shoes and inserts. There is no coinsurance, copayment, or deductible for members eligible for the diabetes self-management training preventive benefit. An office or facility copay may apply if other services are provided during your visit.
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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	20% coinsurance. Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in MediGold Mount Carmel Cash Back No Premium MA Only (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MediGold Mount Carmel Cash Back No Premium MA Only (HMO) is 20% coinsurance.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (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. Emergency care is covered worldwide.	$90 copay per visit If you are admitted to the hospital within 48 hours for the same condition, you pay $0 for the emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. If you receive emergency care outside of the U.S., you may be required to pay for that care and have the plan reimburse you once you return home. Refer to Chapter 5 for more information.
Fitness Services SilverSneakers® Fitness Program is a complete well-being program that includes: • A fitness membership with access to thousands of participating fitness facilities throughout the nation. • Access to fitness facility basic amenities plus group fitness classes taught by certified instructors that focus on agility, balance, cardiovascular health, coordination, flexibility, and range of motion. • Access to SilverSneakers FLEX® which provides options outside of traditional fitness facilities including recreation centers, malls and parks. • Access to a support network and virtual resources through SilverSneakers LIVE™, SilverSneakers On-Demand™ and a mobile app, SilverSneakers GO™. To obtain your SilverSneakers ID number, visit SilverSneakers.com/Eligibility or call 1-888-423-4632	$0 copay for SilverSneakers fitness membership** **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.

Services that are covered for you	**What you must pay** when you get these services
(TTY 711), from 8 a.m. – 8 p.m. ET, Monday through Friday.	
Hearing aid benefit** The hearing aid benefit includes up to two TruHearing hearing aids every year. TruHearing hearing aids include the Advanced and Premium hearing aids offered in an array of colors and styles. The benefit includes a maximum of two hearing aids per year, limited to one per ear per year. Hearing aid purchase includes: • First year of follow-up provider visits with a network provider for fitting and adjustments. • Sixty day trial period money-back guarantee. • Three-year extended warranty for all repairs. • Eighty batteries per hearing aid. To access the hearing aid benefit, call **TruHearing at 1-855-544-7055 (TTY 711),** and a representative will help you set up a hearing exam with a network provider in your area. If hearing loss is discovered, the provider will help you choose and order the right hearing aid(s) for your needs. When the hearing aid(s) is ready, the provider will fit and program it with you in the provider's office. Please note, the benefit does not include any of the following products or services: Ear molds; hearing aid accessories; additional provider visits; extra batteries; hearing aids that are not the TruHearing Advanced or TruHearing Premium; hearing aid return fees; hearing aid restocking fees; or loss and damage warranty claims. Costs associated with excluded products and services are the responsibility of the member and not covered by the plan.	$599 copay for one TruHearing Advanced hearing aid** $899 copay for one TruHearing Premium hearing aid** $0 copay for first year of follow-up visits for hearing aid fitting and adjustments** **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • One routine hearing exam.** • One Medicare-covered exam to diagnose and treat hearing and balance issues each calendar year.	$0 copay for routine hearing exam (up to one per calendar year)** $30 copay for diagnostic exam to treat hearing and/or balance issues each calendar year. **Amounts you pay for some services do not count toward

Services that are covered for you	**What you must pay** when you get these services
	your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
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	$0 copay for home health services. 20% coinsurance when Part B medical equipment and supplies are billed separately.

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Prosthetics and supplies	20% coinsurance for home infusion drug component 20% coinsurance for home infusion therapy supplies Additional copay/coinsurance may apply for professional services based on the provider delivering the service.
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 chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay your	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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO). Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing may apply for outpatient consultations.

Services that are covered for you	**What you must pay** when you get these services
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 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 cost sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by MediGold Mount Carmel Cash Back No Premium MA Only (HMO) but are not covered by Medicare Part A or B: MediGold Mount Carmel Cash Back No Premium MA Only (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
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.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	**What you must pay** when you get these services
• 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.	
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. No limit to the number of days covered by the plan per hospital admission. 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	$75 copay per day for days 1-7 $0 copay per day after day 7 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
MediGold Mount Carmel Cash Back No Premium MA Only (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • 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 "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	
Inpatient services in a psychiatric hospital* • Covered services include mental health care services that require a hospital stay. You receive up to 190 days in an inpatient psychiatric hospital in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	$75 copay per day for days 1-7 $0 copay per day after day 7

Services that are covered for you	**What you must pay** when you get these services
*Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* If the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • 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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	You pay 100% of all charges if you choose to use a non-plan hospital without prior authorization (excluding emergency admissions), or at the point the plan determines your stay is not (or no longer) covered based on medical necessity. In some cases, you are entitled to receive listed services after your SNF days have been exhausted or are no longer covered. Refer to the **Outpatient Services** section within this benefit chart (Chapter 4, Section 2.1) for other copay amounts.
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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	**What you must pay** when you get these services
A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. We also cover some vaccines under our Part B prescription drug benefit.	20% coinsurance

Services that are covered for you	**What you must pay** when you get these services
*Prior authorization rules may apply for select services. Refer to Chapter 4, Section 2.1 for more information.	
Non-Medicare-covered Acupuncture* Acupuncture is often used for pain management including chronic pain, cancer treatment support, headaches, insomnia, anxiety, and addiction support. Covered acupuncture evaluation and management services include a limit of six (6) visits per year. To find an acupuncturist in the plan's network, please visit MediGold.com/Find-a-Provider. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	$20 copay per visit.** This service has a limit six (6) visits per year. **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, 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.	$25 copay.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • COVID-19 testing. • X-rays. • Radiation (radium and isotope) therapy including technician materials and supplies. • Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. • Laboratory tests. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used . • Other outpatient diagnostic tests. • For some non-invasive surgical procedures and tests, refer to the **Outpatient Surgery** section within this benefit chart. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	$25 copay for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder or foot). $0 to $25 copay for diagnostic tests (examples include but are not limited to an electrocardiogram [ECG/EKG], duplex scan of the heart, and esophageal function test) in a physician's office. There is no copay for COVID-19 testing and specified testing-related services. $70 copay for diagnostic radiological services (advanced imaging examples include but are not limited to MRI, CT scan and PET scan). 20% coinsurance for therapeutic radiological services. 20% coinsurance for Part B drugs and contrast materials used in conjunction with outpatient diagnostic services. $0 copay for lab tests. $0 copay for covered blood, blood storage, processing and handling services Refer to the **Outpatient Hospital** and the **Outpatient Surgery** sections within this benefit chart (Chapter 4, Section 2.1) for other copay amounts. Coinsurance and copays are separate member responsibilities. If you receive multiple services from the same provider on the same date, you will be responsible for the

Services that are covered for you	**What you must pay** when you get these services
	highest copay for services in addition to coinsurance, if applicable.
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 online at 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.	$0 copay per visit.
Outpatient hospital services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital	$0 copay for each day associated with an outpatient observation stay. $125 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility. $0 copay for Coumadin clinic visit.

Services that are covered for you	**What you must pay** when you get these services
• 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 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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	$30 copay for treatment in a respiratory therapy department $0 copay for lab tests. $25 copay for x-ray services. $70 copay for diagnostic radiological services. 20% coinsurance for therapeutic radiological services. 20% coinsurance for Part B drugs and biologicals when provided during an outpatient hospital service. If you get a self-administered drug that isn't covered by Medicare Part B while in a hospital outpatient setting, the hospital may bill you for the drug. Refer also to the **Outpatient Diagnostic Tests and Therapeutic Services and Supplies,** the **Outpatient Mental Health Care,** the **Outpatient Surgery** and the **Partial Hospitalization** sections within this benefit chart (Chapter 4, Section 2.1) for other copay amounts. Coinsurance and copays are separate member responsibilities. If you receive multiple services from the same provider on the same date, you will be responsible for the highest copay for services in addition to coinsurance, if applicable. You pay nothing for an outpatient observation stay,

Services that are covered for you	**What you must pay** when you get these services
	however, one copay will apply based on maximum service for all applicable outpatient services provided each day while you are in observation.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$25 copay per individual visit. $25 copay per group visit.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$20 copay per visit.
Outpatient substance abuse services Covered services include: • Alcohol and/or substance abuse assessment and intervention services provided by a Medicare-qualified substance abuse professional as allowed under applicable state laws. • For coverage of smoking and tobacco use cessation, refer to Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) service in this chart.	$25 copay per individual visit. $25 copay per group visit.
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	$125 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility. 20% coinsurance may apply for Part B drugs, durable medical equipment, prosthetic devices

Services that are covered for you	**What you must pay** when you get these services
outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	and supplies when provided during a surgical visit. For some non-invasive surgical procedures and tests (for example, but not limited to: endoscopy, liver biopsy, diagnostic colonoscopy, insertion of urine catheter and certain injections) the outpatient surgery copay will apply. Please contact Member Services with any questions. Refer to the **Outpatient Diagnostic Tests and Therapeutic Services and Supplies** and the **Outpatient Hospital** sections within this benefit chart (Chapter 4, Section 2.1) for other copay amounts. Coinsurance and copays are separate member responsibilities. If you receive multiple services from the same provider on the same date, you will be responsible for the highest copay for services in addition to coinsurance, if applicable.
Over-the-Counter allowance Members receive supplemental coverage for select over-the-counter medications, as well as health and wellness products such as common cold medicine, vitamins, and more. Choose from a wide selection of trusted, quality CVS participating Health branded products without the need for a prescription. Eligible members may order in one of three simple ways: • Visit a participating CVS retail location.	Up to $75 allowance every quarter (three months) for eligible over-the-counter items.** No carryover from previous quarter(s). Member is responsible for the difference if the total exceeds the quarterly $75 allowance. The $75 quarterly allowance may only be exceeded at the

Services that are covered for you	**What you must pay** when you get these services
• Call 1-888-628-2770 (TTY 711), Monday to Friday, 9 a.m. – 8 p.m. • Visit our customized website at www.cvs.com/otchs/MediGold.	retail locations. Orders placed over the phone or on the website must total $75 or less. **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$30 copay per day.
Physician/Practitioner services, including doctor's office visits* Covered services include: o Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. o Consultation, diagnosis, and treatment by a specialist. o Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment. o Certain additional telehealth services, including those rendered by a PCP, specialist, mental health care provider, or psychiatrist. ▪ 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 network provider who offers the service by telehealth. **Members should call their provider first to inquire if telehealth services are available before seeking treatment.**	$0 copay per visit to a primary care provider. $30 copay per visit to a specialist. $30 copay for non-routine dental care. 20% coinsurance for therapeutic radiological services. $0 copay for PCP telehealth $30 copay for Specialist telehealth $25 copay for Mental Health-Individual Sessions telehealth $25 copay for Psychiatric-Individual Sessions telehealth 20% coinsurance for durable medical equipment, the cost of allergy serum, or other Part B drugs administered or dispensed in a physician's office.

Services that are covered for you	**What you must pay** when you get these services
▪ Telehealth services may be conducted by phone, computer, tablet and/or other video-enabled technology. o 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 o Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location o Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location o Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ▪ You have an in-person visit within 6 months prior to your first telehealth visit ▪ You have an in-person visit every 12 months while receiving these telehealth services ▪ Exceptions can be made to the above for certain circumstances o Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers o Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment o Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	$30 copay for basic hearing and balance exam. $25 copay for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder, or foot). $0 to $25 copay for diagnostic tests (examples include but are not limited to an electrocardiogram [ECG/EKG], duplex scan of the heart, and esophageal function test) in a physician's office. There is no copay for COVID-19 testing and specified testing-related services. $70 copay for diagnostic radiological services (advanced imaging examples include but are not limited to MRI, CT scan, and PET scan). $0 copay for lab tests. $0 copay for annual routine physical exam. Coinsurance and copays are separate member responsibilities. If you receive multiple services from the same provider on the same date, you will be responsible for the highest copay for services in addition to coinsurance, if applicable.

Services that are covered for you	**What you must pay** when you get these services
○ Consultation your doctor has with other doctors by phone, internet, or electronic health record **if** you're not a new patient ○ 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) ○ Annual routine physical exam. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	
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.	$30 copay per visit.
Post-Discharge Meals Benefit covers up to 14 meals over a 7 day period. After a qualifying discharge from an Inpatient Hospital or Observation to your home, you may be eligible to receive nutritious meals to help you recover from your injuries or manage your health conditions. Meals may not be merely for convenience or comfort purposes. Meals will be coordinated by GA Foods and delivered to your home.	$0 copay for covered meals** **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.
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.	There is no coinsurance, copayment or deductible for an annual PSA test.
Prosthetic devices and related supplies*	20% coinsurance

Services that are covered for you	**What you must pay** when you get these services
Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	
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.	$20 copay per visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 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 written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). 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."	$0 copay per visit for kidney disease education services in a primary care provider's or specialist's office (a copay will apply if you also are treated for an existing condition during the visit). $0 copay per visit for self-dialysis training if provided in a primary care provider's office. $30 copay per visit for self-dialysis training if provided in a specialist's office. 20% coinsurance per visit for outpatient dialysis treatments (provided in an outpatient facility, an outpatient renal dialysis treatment center or your home). No additional cost for dialysis treatments while admitted to a hospital. $0 copay for home health support services. 20% coinsurance for home dialysis equipment and supplies.
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.") *Plan covers up to 100 days each benefit period. No prior hospital stay is required. Covered services include but are not limited to:* • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services.	$0 copay per day for days 1-20, per SNF stay $196 copay per day for days 21-58, per SNF stay $0 copay per day for days 59-100, per SNF stay A benefit period begins the day you are admitted to a SNF. The benefit period ends when you have not received hospital or SNF care for 60 days in a row. If

Services that are covered for you	**What you must pay** when you get these services
• Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/Practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). **A SNF where your spouse is living at the time you leave the hospital.** *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	you are admitted to the facility after one benefit period ends, a new benefit period begins. There is no limit to the number of benefit periods you may have.
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 2 counseling quit attempts within a 12-month period as a preventive service	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
with no cost to you. Each counseling attempt includes up to 4 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 2 counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to 4 face-to-face visits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). 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 of a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. 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.	$20 copay per visit.
Transportation Non-emergent transportation to plan approved providers and locations (such as primary care, specialty, dental, vision, and pharmacy) throughout Ohio using the plan's transportation service. • Members are required to call at least one (1) business day (24 hours) in advance to schedule transportation. Trips over 75 miles one way require plan approval.	$0 copay for unlimited medically necessary transportation.

Services that are covered for you	**What you must pay** when you get these services
• To schedule transportation, members must call 1-833-944-0516 (TTY 711), Monday – Saturday, 6 a.m. – 8 p.m.	
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. Examples of urgently needed services that the plan must cover out of network are: i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. 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. Urgently needed services are covered worldwide.	$35 copay per urgent care visit within the U.S. $35 copay per pharmacy-based mini clinic visit within the U.S. $90 copay per urgent care visit outside the U.S.
Virtual care visits The virtual care visit combines a traditional nurse advice line with virtual physician consultations. Registered nurses provide the initial triage for symptoms any time of day or night, and provide a recommendation for care. Some situations qualify for additional consultations, in which case the nurse will connect the member with a virtual partner whose physicians will address the member's symptoms. Call 1-855-638-5842, 24 hours a day, 7 days a week for assistance.	$0 copay for virtual care visits.
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-	There is no coinsurance, copayment, or deductible for eligible members for the Medicare-covered glaucoma screening. $0 copay for routine eye exam** (if a medical condition is found and/or treated during a routine eye exam, a copay may apply). $0 copay for diabetic retinopathy screening for people with

Services that are covered for you	**What you must pay** when you get these services
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.) • Hardware allowance every year toward the purchase price of unlimited pairs of contacts, eyeglasses (frames and lenses), eyeglass frames, or eyeglass lenses. In addition to Medicare-covered services, our plan also covers the following with MediGold Vision: • One routine eye exam each calendar year. ** • A $200 allowance every year for non-Medicare covered eyewear. You are responsible for any amount above the coverage limit. Coverage with MediGold Vision includes frames, lenses and contact lenses, and must be obtained through a Spectera contracted provider. It is your responsibility to provide insurance at the time of service to receive the In-Network benefit. The benefit may not be combined with any in-store promotional offers or discounts. Exam does not cover Contact Fittings. The Contact Fitting is not a covered benefit. Note: This allowance does not apply to eyewear obtained following cataract surgery.	diabetes (if other diagnostic or therapeutic services are provided during the same visit, a copay may apply). $30 copay per visit for exams of the eye related to a medical condition. $0 copay for Medicare-covered eyewear up to the Medicare allowable benefit following cataract surgery. $200 allowance for non-Medicare covered eyewear every year, including contact lenses eyeglasses (lenses and/or frames). **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 2.1 for more information.
Visitor/Traveler Benefit When traveling outside the state of Ohio, but within the United States and its territories, members may see out-of-network providers for covered, medically necessary services and pay in-network cost sharing. • Members must contact Member Services at 1-800-240-3851, 8 a.m. - 8 p.m., 7 days a week prior to traveling to initiate the benefit. • If the benefit is not initiated prior to traveling, member will not be able to access the visitor travel benefit. • Members may need prior authorization for some services received while using the visitor travel benefit. Covered services that require prior authorization are	There is a $3,500 allowance towards visitor/travel covered, medically necessary services from out-of-network providers when traveling outside the state of Ohio. Amounts do not carry over from year to year.

Services that are covered for you	**What you must pay** when you get these services
listed in the Medical Benefits chart found in Chapter 4, Section 2.1. • The member, or the out-of-state provider, can request prior authorization by calling the number on the back of the member ID card. • Members are responsible for ensuring prior authorization is in place, if needed prior to rendering services. • Transportation services are not eligible under the visitor travel benefit.	
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

MediGold Enhanced Dental				
Deductible: $0 Combined Annual Plan Maximum: $1,000 Out of Network Allowance: Not Applicable (In Network Only)				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	Periodic Oral Evaluation	0%	Not Covered	2 per calendar year
D0140	Limited Oral Evaluation - Problem Focused	0%	0%	2 per calendar year
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0%	Not Covered	2 per calendar year
D0160	Detailed and extensive oral evaluation - problem-focused, by report	0%	Not Covered	2 per calendar year
D0180	Comprehensive periodontal evaluation - new or established patient	0%	Not Covered	2 per calendar year
D0190	Screening of a patient	0%	Not Covered	Unlimited
D0210	Intraoral - Complete Series Of Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0220	Intraoral - Periapical First Radiographic Image	0%	Not Covered	8 per calendar year
D0230	Intraoral - Periapical Each Additional Radiographic Image	0%	Not Covered	8 per calendar year
D0240	Intraoral - Occlusal Radiographic Image	0%	Not Covered	2 per consecutive 6 months
D0250	Extraoral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	0%	Not Covered	2 per calendar year
D0270	Bitewing - Single Radiographic Image	0%	Not Covered	8 per calendar year
D0272	Bitewings - Two Radiographic Images	0%	Not Covered	4 per calendar year
D0273	Bitewings - Three Radiographic Images	0%	Not Covered	2 per calendar year
D0274	Bitewings - Four Radiographic Images	0%	Not Covered	2 per calendar year

MediGold Enhanced Dental				
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0330	Panoramic Radiographic Image	0%	Not Covered	1 per consecutive 36 months
D0701	D0701-panoramic radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0702	D0702-2-D cephalometric radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0706	D0706-intraoral – occlusal radiographic image – image capture only	0%	Not Covered	2 per consecutive 6 months
D0707	D0707-intraoral – periapical radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0708	D0708-intraoral – bitewing radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0709	D0709-intraoral – complete series of radiographic images – image capture only	0%	Not Covered	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	Not Covered	Unlimited
Preventive				
D1110	Prophylaxis – Adult	0%	Not Covered	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	Not Covered	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	Not Covered	2 per calendar year
D1510	Space Maintainer - Fixed - Unilateral	0%	Not Covered	1 per consecutive 60 months
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months
D1520	Space Maintainer - Removable – Unilateral	0%	Not Covered	1 per consecutive 60 months
D1526	Space Maintainer – Removable – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1527	Space Maintainer – Removable – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months

MediGold Enhanced Dental				
D1551	re-cement or re-bond bilateral space maintainer – maxillary	0%	Not Covered	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer – mandibular	0%	Not Covered	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	Not Covered	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	Not Covered	Unlimited
D1557	removal of fixed bilateral space maintainer – maxillary	0%	Not Covered	Unlimited
D1558	removal of fixed bilateral space maintainer – mandibular	0%	Not Covered	Unlimited
D1575	Distal Shoe Space Maintainer - Fixed Unilateral	0%	Not Covered	1 per consecutive 60 months
D1999	Unspecified preventive procedure, by report	0%	Not Covered	Unlimited
Restorative				
D2140	Amalgam - One Surface, Primary Or Permanent	50%	Not Covered	Unlimited
D2150	Amalgam - Two Surfaces, Primary Or Permanent	50%	Not Covered	Unlimited
D2160	Amalgam - Three Surfaces, Primary Or Permanent	50%	Not Covered	Unlimited
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	50%	Not Covered	Unlimited
D2330	Resin-Based Composite - One Surface, Anterior	50%	Not Covered	Unlimited
D2331	Resin-Based Composite - Two Surfaces, Anterior	50%	Not Covered	Unlimited
D2332	Resin-Based Composite - Three Surfaces, Anterior	50%	Not Covered	Unlimited
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	50%	Not Covered	Unlimited
D2390	Resin-Based Composite Crown, Anterior	50%	Not Covered	1 per consecutive 60 months
D2391	Resin-Based Composite - One Surface, Posterior	50%	Not Covered	Unlimited
D2392	Resin-Based Composite - Two Surfaces, Posterior	50%	Not Covered	Unlimited
D2393	Resin-Based Composite - Three Surfaces, Posterior	50%	Not Covered	Unlimited

MediGold Enhanced Dental				
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	50%	Not Covered	Unlimited
D2910	Recement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	50%	Not Covered	1 per consecutive 12 months
D2915	Recement Or Re-Bond Cast Indirectly Fabricated Or Prefabricated Post And Core	50%	Not Covered	1 per consecutive 12 months
D2920	Recement Or Re-Bond Crown	50%	Not Covered	1 per consecutive 12 months
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	50%	Not Covered	1 per consecutive 6 months
D2940	Protective Restoration	50%	Not Covered	Unlimited
D2941	Interim Therapeutic Restoration-Primary Dentition	50%	Not Covered	Unlimited
D2951	Pin Retention - Per Tooth, In Addition To Restoration	50%	Not Covered	1 per consecutive 60 months
D2980	Crown Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2981	Inlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2982	Onlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	Not Covered	Unlimited
Endodontics				
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime
D3221	Pulpal Debridement, Primary And Permanent Teeth	70%	Not Covered	1 per tooth per lifetime
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	70%	Not Covered	1 per tooth per lifetime
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime

MediGold Enhanced Dental				
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	70%	Not Covered	1 per tooth per lifetime
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	70%	Not Covered	1 per tooth per lifetime
D3333	Internal Tooth Repair Of Performation Defects	70%	Not Covered	1 per tooth per lifetime
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	70%	Not Covered	1 per tooth per lifetime
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	70%	Not Covered	1 per tooth per lifetime
D3348	Retreatment Of Previous Root Canal Therapy - Molar	70%	Not Covered	1 per tooth per lifetime
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc	70%	Not Covered	1 per tooth per lifetime
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	70%	Not Covered	1 per tooth per lifetime
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root	70%	Not Covered	1 per tooth per lifetime
D3410	Apicoectomy - Anterior	70%	Not Covered	1 per tooth per lifetime
D3421	Apicoectomy - Premolar (First Root)	70%	Not Covered	1 per tooth per lifetime
D3425	Apicoectomy - Molar (First Root)	70%	Not Covered	1 per tooth per lifetime
D3426	Apicoectomy (Each Additional Root)	70%	Not Covered	2 per tooth per lifetime
D3430	Retrograde Filling - Per Root	70%	Not Covered	1 per tooth per lifetime
D3450	Root Amputation - Per Root	70%	Not Covered	1 per tooth per lifetime
D3471	D3471-surgical repair of root resorption - anterior	70%	Not Covered	1 per tooth per lifetime
D3472	D3472-surgical repair of root resorption – premolar	70%	Not Covered	1 per tooth per lifetime

MediGold Enhanced Dental				
D3473	D3473-surgical repair of root resorption – molar	70%	Not Covered	1 per tooth per lifetime
D3501	D3501-surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	70%	Not Covered	1 per tooth per lifetime
D3502	D3502-surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	70%	Not Covered	1 per tooth per lifetime
D3503	D3503-surgical exposure of root surface without apicoectomy or repair of root resorption – molar	70%	Not Covered	1 per tooth per lifetime
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	70%	Not Covered	1 per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	70%	Not Covered	Unlimited
Periodontics				
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months
D4240	Gingival Flap Procedure, Including Root Planning - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months
D4241	Gingival Flap Procedure - Including Root Planing -One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months
D4245	Apically Positioned Flap	70%	Not Covered	1 per quadrant per consecutive 36 months
D4249	Clinical Crown Lengthening - Hard Tissue	70%	Not Covered	1 per consecutive 36 months
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months

MediGold Enhanced Dental				
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 36 months
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	70%	Not Covered	1 per consecutive 36 months
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	70%	Not Covered	1 per consecutive 36 months
D4265	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration	70%	Not Covered	1 per consecutive 36 months
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	70%	Not Covered	1 per consecutive 36 months
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	70%	Not Covered	1 per consecutive 36 months
D4268	Surgical Revision Procedure, Per Tooth	70%	Not Covered	1 per consecutive 36 months
D4270	Pedicle Soft Tissue Graft Procedure	70%	Not Covered	1 per consecutive 36 months
D4273	Autogenous Connective Tissue Graft Procedure, Per First Tooth, Implant Or Endentulous Tooth Position In Graft	70%	Not Covered	1 per consecutive 36 months
D4274	Mesial/Distal Wedge Procedure Single Tooth(When Not Performed In Conjunction With Surgical Procedures In The Same Area	70%	Not Covered	1 per consecutive 36 months
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant	70%	Not Covered	1 per consecutive 36 months
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	70%	Not Covered	1 per consecutive 36 months
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites)First Tooth, Implant, Or Edentulous Tooth	70%	Not Covered	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	70%	Not Covered	1 per consecutive 36 months

MediGold Enhanced Dental				
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	70%	Not Covered	1 per consecutive 36 months
D4285	Non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	70%	Not Covered	1 per consecutive 36 months
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 24 months
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	70%	Not Covered	1 per quadrant per consecutive 24 months
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation	70%	Not Covered	2 per consecutive 12 months
D4355	Full Mouth Debridement To Enable A Comprehensive Oral Evaluation And Diagnosis On A Subsequent Visit	70%	Not Covered	1 per consecutive 36 months
D4910	Periodontal Maintenance	70%	Not Covered	2 per calendar year
D4999	Unspecified periodontal procedure, by report	70%	Not Covered	Unlimited
Oral & Maxillofacial Surgery				
D7111	Extraction, Coronal Remnants - Primary Tooth	50%	Not Covered	1 per tooth per lifetime
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	50%	Not Covered	1 per tooth per lifetime
D7210	Extraction, Erupted Tooth Req Removal Of Bone,Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap	50%	Not Covered	1 per tooth per lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	50%	Not Covered	1 per tooth per lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	50%	Not Covered	1 per tooth per lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	50%	Not Covered	1 per tooth per lifetime

MediGold Enhanced Dental				
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical	50%	Not Covered	1 per tooth per lifetime
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	50%	Not Covered	1 per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	Not Covered	Unlimited
D7270	Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	50%	Not Covered	1 per site per lifetime
D7280	Exposure Of An Unerupted Tooth	50%	Not Covered	1 per tooth per lifetime
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	50%	Not Covered	1 per tooth per lifetime
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	50%	Not Covered	1 per tooth per lifetime
D7286	Incisional Biopsy Of Oral Tissue - Soft (All Others)	50%	Not Covered	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	Not Covered	Unlimited
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	50%	Not Covered	1 per tooth per lifetime
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7311	Alveoplasty In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7321	Alveoplasty Not In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	50%	Not Covered	1 per site per visit
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	50%	Not Covered	1 per site per visit
D7910	Suture of recent small wounds up to 5 cm	50%	Not Covered	Unlimited

MediGold Enhanced Dental				
D7970	Excision Of Hyperplastic Tissue - Per Arch	50%	Not Covered	1 per site per consecutive 36 months
D7971	Excision Of Pericoronal Gingiva	50%	Not Covered	1 per site per consecutive 36 months
D7999	Unspecified oral surgery procedure, by report	50%	Not Covered	Unlimited
Adjunctive General Services				
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0%	0%	Unlimited
D9943	Occlusal Adjustment	0%	0%	1 per consecutive 6 months
D9995	teledentistry - synchronous; real-time encounter	0%	0%	2 per calendar year
D9996	teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review	0%	0%	2 per calendar year

DENTAL LIMITATIONS & EXCLUSIONS

LIMITATIONS	
1.	Oral Evaluations (D0120-D0160, D0180) are limited to 2 times per 12 consecutive months.
2.	Intraoral-Complete Series, Vertical Bitewings and Panorex Radiographs (D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.
3.	Intraoral – Periapical radiographs (D0220, D0230) are limited to a total of 8 films per plan year. Intraoral – Occlusal radiograph (D0240) is limited to 2 per consecutive 6 months.
4	Extra-oral Radiographs (D0250) are limited to 2 films per plan year.
5.	Bitewing Radiographs (D0270, D0272, D0273 and D0274) are limited to 2 series of films per plan year.
6.	Dental Prophylaxis (D1110) is limited to 2 times per 12 consecutive months. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346) is limited to 2 times per 12 months.
7.	Fluoride Treatment (D1206 and D1208) is limited to Covered Persons under the age of 16 years and limited to 2 times per consecutive 12 months.

8.	Space Maintainers (D1510, D1516-D1517, D1520, D1526-D1527 and D1575) are limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
9.	Re-cement or re-bond of Space Maintainers (D1550) are limited to 1 per consecutive 6 months after initial insertion.
10.	Removal of Fixed Space Maintainer (D1555) does not have a frequency limit.
11.	Multiple Restorations on 1 surface (D2140, D2330 and D2391) will be treated as a single filling.
12.	Recement Inlays/Onlays (D2910), Crowns (D2920) and Post and Core (D2915) are limited to those performed more than 12 months after the initial insertion. Recements of inlays, onlays, post and cores and crowns are limited to 1 time per consecutive 12 months. Recements of bridges are limited to 1 time per consecutive 6 months.
13.	Crowns (D2390) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth; not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
14	Protective Restorations (D2940) are covered as a separate benefit only if no other service other than X-rays and exam, were done on the same tooth during the visit.
15.	Pin Retention (D2951) is not covered in addition to Cast Restoration. Cast Restoration is defined as inlays and onlays. Limited to 1 time per consecutive 60 months.
16.	Therapeutic Pulpotomy (D3220) is limited to 1 time per primary or secondary tooth per lifetime. Pulpal Therapy/Resorbable Filling (D3230 and D3240) is limited to 1 time per tooth per lifetime; covered for anterior or posterior teeth only.
17.	Pulpal Debridement and Partial Pulpotomy for Apexogenesis (D3221 and D3222) are limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
18.	Root Canal Therapy (D3310 - D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment (D3346, D3347, D3348) for the first 12 months. Retreatment of Root Canals is limited to 1 time per lifetime.
19.	Apexification (D3351, D3352, D3353), Apicoectomy (D3410, D3421, D3425), Retrograde filling (D3430), Root Resection/Amputation (D3450) are limited to 1 time per tooth per lifetime. Apicoectomy – each additional root (D3426) and periradicular surgery without apicoectomy (D3427) is limited to 2 times per tooth per lifetime.
20.	Hemisection (D3920) is limited to 1 time per tooth per lifetime.
21.	Crown Lengthening (D4249), Gingivectomy/Gingivoplasty (D4210, D4211), Gingival Flap Procedure (D4240, D4241, D4245), Osseous Graft (D4263, D4264, D4265), Osseous Surgery (D4260, D4261), Guided Tissue Regeneration (D4266, D4267), Soft Tissue Surgery (D4270, D4273, D4274, D4275, D4276, D4277; D4283, D4285) are limited to 1 per quadrant or site per consecutive 36 months.
22.	Surgical Revision Procedure (D4268) is limited to 1 per consecutive 36 months

23.	Scaling and Root Planing (D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
24.	Full Mouth Debridement (D4355) is limited to 1 time per consecutive 36 months.
25.	Periodontal Maintenance (D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (D4355).
26.	Repairs and Adjustments to Crowns/Inlay/Onlay (D2980-D2982) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months. Reattachment of tooth fragment, incisal edge or cusp (D2921) is limited to 1 per consecutive 6 months.
27.	Simple Extractions (D7111, D7140), Extraction of Erupted Tooth (D7210), Surgical Extraction of Impacted Teeth (D7220, D7230,7240, D7241) Root Removal (D7250) are limited to 1 time per tooth per lifetime.
28.	Placement of Device to Facilitate Eruption of Impacted Tooth (D7283) and Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report (D7291) are limited to 1 per tooth per lifetime.
29.	Tooth Reimplantation and/or Transplantation Services (D7270) are limited to 1 per site per lifetime.
30.	Exposure of an Unerupted Tooth (D7280) is limited to 1 time per tooth per lifetime.
31.	Mobilization of erupted or malpositioned tooth to aid eruption (D7282) is limited to 1 time per tooth per lifetime.
32.	Biopsy (D7286) is limited to 1 biopsy per site per visit.
33.	Surgical Incision (D7510-D7511) is limited to 1 time per site per visit.
34.	Excision of Hyperplastic Tissue or Pericoronal Gingivia (D7970 and D7971) is limited to 1 per site per consecutive 36 months.
35.	Palliative Treatment (D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.
36.	Occlusal Guard Adjustments (D9943) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months

EXCLUSIONS	
General Exclusions (The following are not covered.)	
1.	Dental Services that are not necessary.
2.	Hospitalization or other facility charges.

3.	Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
4.	Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5.	Any dental procedure not directly associated with dental disease.
6.	Any procedure not performed in a dental setting.
7.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or
9.	Expenses for dental procedures that began prior to the Covered Person becoming enrolled under the Policy.
10.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11.	Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12.	Foreign services are not covered unless required as an emergency.
13.	Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).
14.	Placement of dental implants, implant-supported abutments and prostheses (D6010; D6012-D3019; D6021-D6052 D6055-D6077; D6080-D6199).
15.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital malformations of hard or soft tissue, including excision (D7413-D7415, D7440-D7441, D7490).
16.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610 – D7780).
17	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810 – D7899). Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment, or treatment for the temporomandibular joint.

18.	Acupuncture; acupressure and other forms of alternative treatment whether or not used as anesthesia.
19.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
20.	In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
21.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Section 2.2 Extra "optional supplemental" benefits you can buy

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

Services that are covered for you	**What you must pay** when you get these services
Optional Supplemental Dental Services** Members may separately purchase the Optional Supplemental Dental benefit. The plan offers the Dental Silver benefit. The premium for the Dental Silver benefit is **$16** per month. **You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable).** Covered services include: • Emergency palliative treatment – to temporarily relieve pain. • Radiographs – bitewing (twice per calendar year); full mouth X-rays, which include bitewings (once in any three-year period). • All other radiographs – other X-rays. • Diagnostic services. • Extractions – non-surgical removal of teeth. • Restorative services – fillings and crown repair. • Endodontic services – root canals.	$0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. 0% - 50% coinsurance for restorative services. There is an annual maximum benefit limit of $1,500. **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.

Services that are covered for you	**What you must pay** when you get these services
• Periodontic services – to treat gum disease. • Other oral surgery – dental surgery. Note: See the chart below for a detailed listing of all dental benefits and exclusions. Important: For more information or assistance finding a dental plan network provider near you, call MediGold Dental at 1-866-209-3212 (TTY 711), 8 a.m. – 8 p.m., Monday - Friday. HMO members who separately purchase the Optional Supplemental Dental benefit must receive both preventive and comprehensive care from a MediGold Dental network provider to be covered. Dental benefits are administered by Dental Benefit Providers.	

Services that are covered for you	**What you must pay** when you get these services
Optional Supplemental Dental Services** Members may separately purchase the Optional Supplemental Dental benefit. The plan offers the Dental Gold benefit. The premium for the Dental Gold benefit is **$34** per month. **You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable).** Covered services include: • Emergency palliative treatment – to temporarily relieve pain. • Radiographs – bitewing (twice per calendar year); full mouth X-rays, which include bitewings (once in any three-year period). • All other radiographs – other X-rays. • Diagnostic services. • Extractions – non-surgical removal of teeth. • Restorative services – fillings and crown repair. • Endodontic services – root canals.	$0 copay for diagnostic and preventive services, emergency palliative treatment and X-rays. 50% coinsurance for extractions, endodontic services, periodontic services and other oral surgery. 0% - 50% coinsurance for restorative services. 50% coinsurance for crowns, bridges and dentures. There is an annual maximum benefit limit of $2,000. **Amounts you pay for some services do not count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.

Services that are covered for you	**What you must pay** when you get these services
• Periodontic services – to treat gum disease. • Other oral surgery – dental surgery. • Crowns, bridges and dentures. Note: See the chart below for a detailed listing of all dental benefits and exclusions. Important: For more information or assistance finding a dental plan network provider near you, call MediGold Dental at 1-866-209-3212 (TTY 711), 8 a.m. – 8 p.m., Monday - Friday. HMO members who separately purchase the Optional Supplemental Dental benefit must receive both preventive and comprehensive care from a MediGold Dental network provider to be covered. Dental benefits are administered by Dental Benefit Providers.	

MediGold Dental Silver				
Deductible: $0 Combined Annual Plan Maximum: $1,500 Out of Network Allowance: Not Applicable (In Network Only)				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	Periodic Oral Evaluation	0%	Not Covered	2 per calendar year
D0140	Limited Oral Evaluation - Problem Focused	0%	0%	2 per calendar year
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0%	Not Covered	2 per calendar year
D0160	Detailed and extensive oral evaluation - problem-focused, by report	0%	Not Covered	2 per calendar year
D0180	Comprehensive periodontal evaluation - new or established patient	0%	Not Covered	2 per calendar year
D0190	Screening of a patient	0%	Not Covered	Unlimited
D0210	Intraoral - Complete Series Of Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0220	Intraoral - Periapical First Radiographic Image	0%	Not Covered	8 per calendar year
D0230	Intraoral - Periapical Each Additional Radiographic Image	0%	Not Covered	8 per calendar year
D0240	Intraoral - Occlusal Radiographic Image	0%	Not Covered	2 per consecutive 6 months
D0250	Extraoral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	0%	Not Covered	2 per calendar year
D0270	Bitewing - Single Radiographic Image	0%	Not Covered	8 per calendar year
D0272	Bitewings - Two Radiographic Images	0%	Not Covered	4 per calendar year
D0273	Bitewings - Three Radiographic Images	0%	Not Covered	2 per calendar year
D0274	Bitewings - Four Radiographic Images	0%	Not Covered	2 per calendar year

MediGold Dental Silver				
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0%	Not Covered	1 per consecutive 36 months
D0330	Panoramic Radiographic Image	0%	Not Covered	1 per consecutive 36 months
D0701	D0701-panoramic radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0702	D0702-2-D cephalometric radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0706	D0706-intraoral – occlusal radiographic image – image capture only	0%	Not Covered	2 per consecutive 6 months
D0707	D0707-intraoral – periapical radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0708	D0708-intraoral – bitewing radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0709	D0709-intraoral – complete series of radiographic images – image capture only	0%	Not Covered	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	Not Covered	Unlimited
Preventive				
D1110	Prophylaxis - Adult	0%	Not Covered	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	Not Covered	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	Not Covered	2 per calendar year
D1510	Space Maintainer - Fixed - Unilateral	0%	Not Covered	1 per consecutive 60 months
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months
D1520	Space Maintainer - Removable - Unilateral	0%	Not Covered	1 per consecutive 60 months
D1526	Space Maintainer – Removable – Bilateral, Maxillary	0%	Not Covered	1 per consecutive 60 months
D1527	Space Maintainer – Removable – Bilateral, Mandibular	0%	Not Covered	1 per consecutive 60 months

MediGold Dental Silver				
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	Not Covered	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	Not Covered	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	Not Covered	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	Not Covered	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	Not Covered	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	Not Covered	Unlimited
D1575	Distal Shoe Space Maintainer - Fixed Unilateral	0%	Not Covered	1 per consecutive 60 months
D1999	Unspecified preventive procedure, by report	0%	Not Covered	Unlimited
Restorative				
D2140	Amalgam - One Surface, Primary Or Permanent	0%	Not Covered	Unlimited
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0%	Not Covered	Unlimited
D2330	Resin-Based Composite - One Surface, Anterior	0%	Not Covered	Unlimited
D2331	Resin-Based Composite - Two Surfaces, Anterior	0%	Not Covered	Unlimited
D2332	Resin-Based Composite - Three Surfaces, Anterior	0%	Not Covered	Unlimited
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0%	Not Covered	Unlimited
D2390	Resin-Based Composite Crown, Anterior	50%	Not Covered	1 per consecutive 60 months
D2391	Resin-Based Composite - One Surface, Posterior	0%	Not Covered	Unlimited
D2392	Resin-Based Composite - Two Surfaces, Posterior	0%	Not Covered	Unlimited
D2393	Resin-Based Composite - Three Surfaces, Posterior	0%	Not Covered	Unlimited

MediGold Dental Silver				
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0%	Not Covered	Unlimited
D2910	Recement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	50%	Not Covered	1 per consecutive 12 months
D2915	Recement Or Re-Bond Cast Indirectly Fabricated Or Prefabricated Post And Core	50%	Not Covered	1 per consecutive 12 months
D2920	Recement Or Re-Bond Crown	50%	Not Covered	1 per consecutive 12 months
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	50%	Not Covered	1 per consecutive 6 months
D2940	Protective Restoration	50%	Not Covered	Unlimited
D2941	Interim Therapeutic Restoration-Primary Dentition	50%	Not Covered	Unlimited
D2951	Pin Retention - Per Tooth, In Addition To Restoration	50%	Not Covered	1 per consecutive 60 months
D2980	Crown Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2981	Inlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2982	Onlay Repair Necessitated By Restorative Material Failure	50%	Not Covered	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	Not Covered	Unlimited
Endodontics				
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3221	Pulpal Debridement, Primary And Permanent Teeth	50%	50%	1 per tooth per lifetime
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	50%	Not Covered	1 per tooth per lifetime
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime

MediGold Dental Silver				
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	50%	Not Covered	1 per tooth per lifetime
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	50%	Not Covered	1 per tooth per lifetime
D3333	Internal Tooth Repair Of Performation Defects	50%	Not Covered	1 per tooth per lifetime
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	50%	Not Covered	1 per tooth per lifetime
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	50%	Not Covered	1 per tooth per lifetime
D3348	Retreatment Of Previous Root Canal Therapy - Molar	50%	Not Covered	1 per tooth per lifetime
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc	50%	Not Covered	1 per tooth per lifetime
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	50%	Not Covered	1 per tooth per lifetime
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root	50%	Not Covered	1 per tooth per lifetime
D3410	Apicoectomy - Anterior	50%	Not Covered	1 per tooth per lifetime
D3421	Apicoectomy - Premolar (First Root)	50%	Not Covered	1 per tooth per lifetime
D3425	Apicoectomy - Molar (First Root)	50%	Not Covered	1 per tooth per lifetime
D3426	Apicoectomy (Each Additional Root)	50%	Not Covered	2 per tooth per lifetime
D3430	Retrograde Filling - Per Root	50%	Not Covered	1 per tooth per lifetime
D3450	Root Amputation - Per Root	50%	Not Covered	1 per tooth per lifetime
D3471	D3471-surgical repair of root resorption - anterior	50%	Not Covered	1 per tooth per lifetime
D3472	D3472-surgical repair of root resorption – premolar	50%	Not Covered	1 per tooth per lifetime

MediGold Dental Silver				
D3473	D3473-surgical repair of root resorption – molar	50%	Not Covered	1 per tooth per lifetime
D3501	D3501-surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	50%	Not Covered	1 per tooth per lifetime
D3502	D3502-surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	50%	Not Covered	1 per tooth per lifetime
D3503	D3503-surgical exposure of root surface without apicoectomy or repair of root resorption – molar	50%	Not Covered	1 per tooth per lifetime
D3911	intraoffice barrier	50%	Not Covered	Unlimited
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	50%	Not Covered	1 per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	50%	Not Covered	Unlimited
Periodontics				
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4240	Gingival Flap Procedure, Including Root Planning - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4241	Gingival Flap Procedure - Including Root Planing -One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4245	Apically Positioned Flap	50%	Not Covered	1 per quadrant per consecutive 36 months
D4249	Clinical Crown Lengthening - Hard Tissue	50%	Not Covered	1 per consecutive 36 months
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months

MediGold Dental Silver				
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 36 months
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	50%	Not Covered	1 per consecutive 36 months
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	50%	Not Covered	1 per consecutive 36 months
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	50%	Not Covered	1 per consecutive 36 months
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	50%	Not Covered	1 per consecutive 36 months
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	50%	Not Covered	1 per consecutive 36 months
D4268	Surgical Revision Procedure, Per Tooth	50%	Not Covered	1 per consecutive 36 months
D4270	Pedicle Soft Tissue Graft Procedure	50%	Not Covered	1 per consecutive 36 months
D4273	Autogenous Connective Tissue Graft Procedure, Per First Tooth, Implant Or Endentulous Tooth Position In Graft	50%	Not Covered	1 per consecutive 36 months
D4274	Mesial/Distal Wedge Procedure Single Tooth(When Not Performed In Conjunction With Surgical Procedures In The Same Area	50%	Not Covered	1 per consecutive 36 months
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant	50%	Not Covered	1 per consecutive 36 months
D4276	Combined connective tissue and pedicle graft, per tooth	50%	Not Covered	1 per consecutive 36 months
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites)First Tooth, Implant, Or Edentulous Tooth	50%	Not Covered	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	50%	Not Covered	1 per consecutive 36 months

MediGold Dental Silver				
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months
D4285	Non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 24 months
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	50%	Not Covered	1 per quadrant per consecutive 24 months
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation	50%	Not Covered	2 per consecutive 12 months
D4355	Full Mouth Debridement To Enable A Comprehensive Oral Evaluation And Diagnosis On A Subsequent Visit	50%	Not Covered	1 per consecutive 36 months
D4910	Periodontal Maintenance	50%	Not Covered	2 per calendar year
D4999	Unspecified periodontal procedure, by report	50%	Not Covered	Unlimited
Oral & Maxillofacial Surgery				
D7111	Extraction, Coronal Remnants - Primary Tooth	50%	Not Covered	1 per tooth per lifetime
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	50%	Not Covered	1 per tooth per lifetime
D7210	Extraction, Erupted Tooth Req Removal Of Bone,Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap	50%	Not Covered	1 per tooth per lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	50%	Not Covered	1 per tooth per lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	50%	Not Covered	1 per tooth per lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	50%	Not Covered	1 per tooth per lifetime

MediGold Dental Silver				
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical	50%	Not Covered	1 per tooth per lifetime
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	50%	Not Covered	1 per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	Not Covered	Unlimited
D7270	Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	50%	Not Covered	1 per site per lifetime
D7280	Exposure Of An Unerupted Tooth	50%	Not Covered	1 per tooth per lifetime
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	50%	Not Covered	1 per tooth per lifetime
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	50%	Not Covered	1 per tooth per lifetime
D7286	Incisional Biopsy Of Oral Tissue - Soft (All Others)	50%	Not Covered	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	Not Covered	Unlimited
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	50%	Not Covered	1 per tooth per lifetime
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7311	Alveoplasty In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7321	Alveoplasty Not In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	Not Covered	Unlimited
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	50%	Not Covered	1 per site per visit
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	50%	Not Covered	1 per site per visit

MediGold Dental Silver				
D7910	Suture of recent small wounds up to 5 cm	50%	Not Covered	Unlimited
D7970	Excision Of Hyperplastic Tissue - Per Arch	50%	Not Covered	1 per site per consecutive 36 months
D7971	Excision Of Pericoronal Gingiva	50%	Not Covered	1 per site per consecutive 36 months
D7999	Unspecified oral surgery procedure, by report	50%	Not Covered	Unlimited
Adjunctive General Services				
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0%	0%	Unlimited
D9912	pre-visit patient screening	0%	0%	2 per calendar year
D9943	Occlusal Adjustment	50%	Not Covered	1 per consecutive 6 months
D9948	adjustment of custom sleep apnea appliance	0%	Not Covered	1 per consecutive 6 months
D9995	teledentistry - synchronous; real-time encounter	0%	0%	2 per calendar year
D9996	teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review	0%	0%	2 per calendar year

DENTAL LIMITATIONS & EXCLUSIONS

LIMITATIONS	
1.	Oral Evaluations (D0120-D0160, D0180) are limited to 2 times per 12 consecutive months.
2.	Intraoral-Complete Series, Vertical Bitewings and Panorex Radiographs (D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.
3.	Intraoral – Periapical radiographs (D0220, D0230) are limited to a total of 8 films per plan year. Intraoral – Occlusal radiograph (D0240) is limited to 2 per consecutive 6 months.
4	Extra-oral Radiographs (D0250) are limited to 2 films per plan year.
5.	Bitewing Radiographs (D0270, D0272, D0273 and D0274) are limited to 2 series of films per plan year.

6.	Dental Prophylaxis (D1110) is limited to 2 times per 12 consecutive months. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346) is limited to 2 times per 12 months.
7.	Fluoride Treatment (D1206 and D1208) is limited to Covered Persons under the age of 16 years and limited to 2 times per consecutive 12 months.
8.	Space Maintainers (D1510, D1516-D1517, D1520, D1526-D1527 and D1575) are limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
9.	Re-cement or re-bond of Space Maintainers (D1550) are limited to 1 per consecutive 6 months after initial insertion.
10.	Removal of Fixed Space Maintainer (D1555) does not have a frequency limit.
11.	Multiple Restorations on 1 surface (D2140, D2330 and D2391) will be treated as a single filling.
12.	Recement Inlays/Onlays (D2910), Crowns (D2920) and Post and Core (D2915) are limited to those performed more than 12 months after the initial insertion. Recements of inlays, onlays, post and cores and crowns are limited to 1 time per consecutive 12 months. Recements of bridges are limited to 1 time per consecutive 6 months.
13.	Crowns (D2390) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth; not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.
14.	Protective Restorations (D2940) are covered as a separate benefit only if no other service other than X-rays and exam, were done on the same tooth during the visit.
15.	Pin Retention (D2951) is not covered in addition to Cast Restoration. Cast Restoration is defined as inlays and onlays. Limited to 1 time per consecutive 60 months.
16.	Therapeutic Pulpotomy (D3220) is limited to 1 time per primary or secondary tooth per lifetime. Pulpal Therapy/Resorbable Filling (D3230 and D3240) is limited to 1 time per tooth per lifetime; covered for anterior or posterior teeth only.
17	Pulpal Debridement and Partial Pulpotomy for Apexogenesis (D3221 and D3222) are limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
18.	Root Canal Therapy (D3310 - D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment (D3346, D3347, D3348) for the first 12 months. Retreatment of Root Canals is limited to 1 time per lifetime.
19.	Apexification (D3351, D3352, D3353), Apicoectomy (D3410, D3421, D3425), Retrograde filling (D3430), Root Resection/Amputation (D3450) are limited to 1 time per tooth per lifetime. Apicoectomy – each additional root (D3426) and periradicular surgery without apicoectomy (D3427) is limited to 2 times per tooth per lifetime.
20.	Hemisection (D3920) is limited to 1 time per tooth per lifetime.
21.	Crown Lengthening (D4249), Gingivectomy/Gingivoplasty (D4210, D4211), Gingival Flap Procedure (D4240, D4241, D4245), Osseous Graft (D4263, D4264, D4265), Osseous

	Surgery (D4260, D4261), Guided Tissue Regeneration (D4266, D4267), Soft Tissue Surgery (D4270, D4273, D4274, D4275, D4276, D4277; D4283, D4285) are limited to 1 per quadrant or site per consecutive 36 months.
22.	Surgical Revision Procedure (D4268) is limited to 1 per consecutive 36 months
23.	Scaling and Root Planing (D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
24.	Full Mouth Debridement (D4355) is limited to 1 time per consecutive 36 months.
25.	Periodontal Maintenance (D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (D4355).
26.	Repairs and Adjustments to Crowns/Inlay/Onlay (D2980-D2982) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months. Reattachment of tooth fragment, incisal edge or cusp (D2921) is limited to 1 per consecutive 6 months.
27.	Simple Extractions (D7111, D7140), Extraction of Erupted Tooth (D7210), Surgical Extraction of Impacted Teeth (D7220, D7230,7240, D7241) Root Removal (D7250) are limited to 1 time per tooth per lifetime.
28.	Placement of Device to Facilitate Eruption of Impacted Tooth (D7283) and Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report (D7291) are limited to 1 per tooth per lifetime.
29.	Tooth Reimplantation and/or Transplantation Services (D7270) are limited to 1 per site per lifetime.
30.	Exposure of an Unerupted Tooth (D7280) is limited to 1 time per tooth per lifetime.
31.	Mobilization of erupted or malpositioned tooth to aid eruption (D7282) is limited to 1 time per tooth per lifetime.
32.	Biopsy (D7286) is limited to 1 biopsy per site per visit.
33.	Surgical Incision (D7510-D7511) is limited to 1 time per site per visit.
34.	Excision of Hyperplastic Tissue or Pericoronal Gingivia (D7970 and D7971) is limited to 1 per site per consecutive 36 months.
35.	Palliative Treatment (D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.
36.	Occlusal Guard Adjustments (D9943) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months

EXCLUSIONS
General Exclusions (The following are not covered.)

1.	Dental Services that are not necessary.
2.	Hospitalization or other facility charges.
3.	Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
4.	Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5.	Any dental procedure not directly associated with dental disease.
6.	Any procedure not performed in a dental setting.
7.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9.	Expenses for dental procedures that began prior to the Covered Person becoming enrolled under the Policy.
10.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11.	Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12.	Foreign services are not covered unless required as an emergency.
13.	Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).
14.	Placement of dental implants, implant-supported abutments and prostheses (D6010; D6012-D3019; D6021-D6052 D6055-D6077; D6080-D6199).
15.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital malformations of hard or soft tissue, including excision (D7413-D7415, D7440-D7441, D7490).
16.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610 – D7780).

17.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810 – D7899). Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment, or treatment for the temporomandibular joint.
18.	Acupuncture; acupressure and other forms of alternative treatment whether or not used as anesthesia.
19.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
20.	In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
21.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

MediGold Dental Gold				
Deductible: $0 Combined Annual Plan Maximum: $2,000 Out of Network Allowance: Not Applicable (In Network Only)				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	periodic oral evaluation	0%	Not Covered	2 per calendar year
D0140	limited oral evaluation - problem focused	0%	0%	2 per calendar year
D0150	comprehensive oral evaluation - new or established patient	0%	Not Covered	2 per calendar year
D0160	detailed and extensive oral evaluation - problem-focused, by report	0%	Not Covered	2 per calendar year
D0170	re-evaluation, limited, problem focused	0%	Not Covered	2 per calendar year
D0180	comprehensive periodontal evaluation - new or established patient	0%	Not Covered	2 per calendar year
D0190	Screening of a patient	0%	Not Covered	Unlimited
D0210	intraoral - complete series of radiographic images	0%	Not Covered	1 per consecutive 36 months

MediGold Dental Gold				
D0220	intraoral - periapical first radiographic image	0%	Not Covered	8 per calendar year
D0230	intraoral - periapical each additional radiographic image	0%	Not Covered	8 per calendar year
D0240	intraoral - occlusal radiographic image	0%	Not Covered	2 per consecutive 6 months
D0250	extraoral - 2D projection radiographic image created using a stationary radiation source and detector	0%	Not Covered	2 per calendar year
D0251	extra-oral posterior dental radiographic image	0%	Not Covered	2 per calendar year
D0270	bitewing - single radiographic image	0%	Not Covered	8 per calendar year
D0272	bitewings - two radiographic images	0%	Not Covered	4 per calendar year
D0273	bitewings - three radiographic images	0%	Not Covered	2 per calendar year
D0274	bitewings - four radiographic images	0%	Not Covered	2 per calendar year
D0277	vertical bitewings - 7 to 8 radiographic images	0%	Not Covered	1 per consecutive 36 months
D0330	panoramic radiographic image	0%	Not Covered	1 per consecutive 36 months
D0350	2D Oral/facial photographic images obtained intraorally or extraorally	0%	Not Covered	1 per consecutive 36 months
D0351	3D photographic image	0%	Not Covered	1 per consecutive 36 months
D0364	cone beam CT capture and interpretation with limited field of view - less than one whole jaw	50%	Not Covered	1 per consecutive 60 months
D0365	cone beam CT capture and interpretation with field of view of one full dental arch - mandible	50%	Not Covered	1 per consecutive 60 months
D0366	cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	50%	Not Covered	1 per consecutive 60 months
D0367	cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	50%	Not Covered	1 per consecutive 60 months
D0411	HbA1c in office point of service testing	0%	Not Covered	No frequency limitation

MediGold Dental Gold				
D0414	Lab processing of microbial specimen to include culture and sensitivity studies.	0%	Not Covered	No frequency limitation
D0415	collection of microorganisms for culture and sensitivity	0%	Not Covered	No frequency limitation
D0416	viral culture	0%	Not Covered	No frequency limitation
D0417	collection and preparation of saliva sample for laboratory diagnostic testing	0%	Not Covered	No frequency limitation
D0418	analysis of saliva sample	0%	Not Covered	No frequency limitation
D0422	collection and preparation of genetic sample material for laboratory analysis and report	0%	Not Covered	No frequency limitation
D0423	genetic test for susceptibility to diseases-specimen analysis	0%	Not Covered	No frequency limitation
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	0%	Not Covered	1 per consecutive 12 months
D0460	pulp vitality tests	0%	Not Covered	1 charge per visit, regardless of how many teeth are tested.
D0470	diagnostic casts	0%	Not Covered	1 per consecutive 24 months
D0600	non-ionizing diagnostic procedure	0%	Not Covered	No frequency limitation
D0601	caries risk assessment and documentation, with a finding of low risk	0%	Not Covered	2 per consecutive 12 months
D0602	caries risk assessment and documentation, with a finding of moderate risk	0%	Not Covered	2 per consecutive 12 months
D0603	caries risk assessment and documentation, with a finding of high risk	0%	Not Covered	2 per consecutive 12 months
D0604	antigen testing for a public health related pathogen, including coronavirus	0%	Not Covered	Unlimited

MediGold Dental Gold				
D0605	antibody testing for a public health related pathogen, including coronavirus	0%	Not Covered	Unlimited
D0606	molecular testing for public health related pathogen, including coronavirus	0%	Not Covered	Unlimited
D0701	panoramic radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0702	2-D cephalometric radiographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	0%	Not Covered	1 per consecutive 36 months
D0704	3-D photographic image – image capture only	0%	Not Covered	1 per consecutive 36 months
D0705	extra-oral posterior dental radiographic image – image capture only	0%	Not Covered	2 per calendar year
D0706	intraoral – occlusal radiographic image – image capture only	0%	Not Covered	2 per consecutive 6 months
D0707	intraoral – periapical radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0708	intraoral – bitewing radiographic image – image capture only	0%	Not Covered	8 per calendar year
D0709	intraoral – complete series of radiographic images – image capture only	0%	Not Covered	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	Not Covered	Unlimited
Preventive				
D1110	prophylaxis - adult	0%	Not Covered	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	Not Covered	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	Not Covered	2 per calendar year
D1354	application of caries arresting medicament – per tooth	0%	Not Covered	No frequency limitation
D1355	caries preventive medicament application – per tooth	0%	Not Covered	2 per consecutive 12 months
D1510	space maintainer - fixed, unilateral - per quadrant	0%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D1516	space maintainer - fixed - bilateral, maxillary	0%	Not Covered	1 per consecutive 60 months
D1517	space maintainer - fixed - bilateral, mandibular	0%	Not Covered	1 per consecutive 60 months
D1520	space maintainer - removable, unilateral - per quadrant	0%	Not Covered	1 per consecutive 60 months
D1526	space maintainer - removable - bilateral, maxillary	0%	Not Covered	1 per consecutive 60 months
D1527	space maintainer - removable - bilateral, mandibular	0%	Not Covered	1 per consecutive 60 months
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	Not Covered	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	Not Covered	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	Not Covered	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	Not Covered	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	Not Covered	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	Not Covered	Unlimited
D1575	distal shoe space maintainer - fixed, unilateral - per quadrant	0%	Not Covered	1 per consecutive 60 months
D1701	Pfizer-BioNTech Covid-19 vaccine administration - first dose	0%	Not Covered	Unlimited
D1702	Pfizer-BioNTech Covid-19 vaccine administration - second dose	0%	Not Covered	Unlimited
D1703	Moderna Covid-19 vaccine administration - first dose	0%	Not Covered	Unlimited
D1704	Moderna Covid-19 vaccine administration - second dose	0%	Not Covered	Unlimited
D1705	AstraZeneca Covid-19 vaccine administration - first dose	0%	Not Covered	Unlimited
D1706	AstraZeneca Covid-19 vaccine administration - second dose	0%	Not Covered	Unlimited
D1707	Janssen Covid-19 vaccine administration	0%	Not Covered	Unlimited
D1999	Unspecified preventive procedure, by report	0%	Not Covered	Unlimited
Restorative				

MediGold Dental Gold				
D2140	amalgam - one surface, primary or permanent	0%	Not Covered	No frequency limitation
D2150	amalgam - two surfaces, primary or permanent	0%	Not Covered	No frequency limitation
D2160	amalgam - three surfaces, primary or permanent	0%	Not Covered	No frequency limitation
D2161	amalgam - four or more surfaces, primary or permanent	0%	Not Covered	No frequency limitation
D2330	resin-based composite - one surface, anterior	0%	Not Covered	No frequency limitation
D2331	resin-based composite - two surfaces, anterior	0%	Not Covered	No frequency limitation
D2332	resin-based composite - three surfaces, anterior	0%	Not Covered	No frequency limitation
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0%	Not Covered	No frequency limitation
D2390	resin-based composite crown, anterior	0%	Not Covered	1 per consecutive 60 months
D2391	resin-based composite - one surface, posterior	0%	Not Covered	No frequency limitation
D2392	resin-based composite - two surfaces, posterior	0%	Not Covered	No frequency limitation
D2393	resin-based composite - three surfaces, posterior	0%	Not Covered	No frequency limitation
D2394	resin-based composite - four or more surfaces, posterior	0%	Not Covered	No frequency limitation
D2410	gold foil - one surface	50%	Not Covered	No frequency limitation
D2420	gold foil - two surfaces	50%	Not Covered	No frequency limitation
D2430	gold foil - three surfaces	50%	Not Covered	No frequency limitation
D2510	inlay - metallic - one surface	50%	Not Covered	1 per consecutive 60 months
D2520	inlay - metallic - two surfaces	50%	Not Covered	1 per consecutive 60 months
D2530	inlay - metallic - three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2542	onlay metallic, two surfaces	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D2543	onlay-metallic-three surfaces	50%	Not Covered	1 per consecutive 60 months
D2544	onlay-metallic-four or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2610	inlay - porcelain/ceramic - one surface	50%	Not Covered	1 per consecutive 60 months
D2620	inlay - porcelain/ceramic - two surfaces	50%	Not Covered	1 per consecutive 60 months
D2630	inlay - porcelain/ceramic - three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2642	onlay - porcelain/ceramic - two surfaces	50%	Not Covered	1 per consecutive 60 months
D2643	onlay - porcelain/ceramic - three surfaces	50%	Not Covered	1 per consecutive 60 months
D2644	onlay - porcelain/ceramic - four or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2650	inlay - composite/resin - one surface	50%	Not Covered	1 per consecutive 60 months
D2651	inlay - composite/resin - two surfaces	50%	Not Covered	1 per consecutive 60 months
D2652	inlay - composite/resin - three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2662	onlay - composite/resin - two surfaces	50%	Not Covered	1 per consecutive 60 months
D2663	onlay - composite/resin - three surfaces	50%	Not Covered	1 per consecutive 60 months
D2664	onlay - composite/resin - four or more surfaces	50%	Not Covered	1 per consecutive 60 months
D2710	crown,resin-based composite (indirect)	50%	Not Covered	1 per consecutive 60 months
D2712	crown - 3/4 resin-based composite (indirect)	50%	Not Covered	1 per consecutive 60 months
D2720	crown - resin with high noble metal	50%	Not Covered	1 per consecutive 60 months
D2721	crown - resin with predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D2722	crown - resin with noble metal	50%	Not Covered	1 per consecutive 60 months
D2740	crown - porcelain/ceramic	50%	Not Covered	1 per consecutive 60 months
D2750	crown - porcelain fused to high noble metal	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D2751	crown - porcelain fused to predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D2752	crown - porcelain fused to noble metal	50%	Not Covered	1 per consecutive 60 months
D2780	crown, 3/4 cast high noble metal	50%	Not Covered	1 per consecutive 60 months
D2781	crown, 3/4 cast predominately base metal	50%	Not Covered	1 per consecutive 60 months
D2782	crown, 3/4 cast noble metal	50%	Not Covered	1 per consecutive 60 months
D2783	crown, 3/4 porcelain/ceramic	50%	Not Covered	1 per consecutive 60 months
D2790	crown - full cast high noble metal	50%	Not Covered	1 per consecutive 60 months
D2791	crown - full cast predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D2792	crown - full cast noble metal	50%	Not Covered	1 per consecutive 60 months
D2794	crown - titanium	50%	Not Covered	1 per consecutive 60 months
D2799	interim crown – further treatment or completion of diagnosis necessary prior to final impression	50%	Not Covered	1 per consecutive 60 months
D2910	recement or re-bond inlay, onlay, veneer or partial coverage restoration	50%	Not Covered	1 per consecutive 12 months
D2915	recement or re-bond cast indirectly fabricated or prefabricated post and core	50%	Not Covered	1 per consecutive 12 months
D2920	recement or re-bond crown	50%	Not Covered	1 per consecutive 12 months
D2921	reattachment of tooth fragment, incisal edge or cusp	50%	Not Covered	1 per consecutive 6 months
D2930	prefabricated stainless steel crown - primary tooth	50%	Not Covered	1 per consecutive 60 months
D2931	prefabricated stainless steel crown - permanent tooth	50%	Not Covered	1 per consecutive 60 months
D2932	prefabricated resin crown	50%	Not Covered	1 per consecutive 60 months
D2933	prefabricated stainless steel crown with resin window	50%	Not Covered	1 per consecutive 60 months
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D2940	protective restoration	50%	Not Covered	No frequency limitation
D2941	interim therapeutic restoration-primary dentition	50%	Not Covered	No frequency limitation
D2950	Core buildup, including any pins when required	50%	Not Covered	1 per consecutive 60 months
D2951	pin retention - per tooth, in addition to restoration	50%	Not Covered	1 per consecutive 60 months
D2952	cast post and core in addition to crown	50%	Not Covered	1 per consecutive 60 months
D2953	each additional indirectly fabricated post, same tooth	50%	Not Covered	1 per consecutive 60 months
D2954	prefabricated post and core in addition to crown	50%	Not Covered	1 per consecutive 60 months
D2957	each additional prefabricated post, same tooth	50%	Not Covered	1 per consecutive 60 months
D2960	labial veneer (laminate) - chairside	50%	Not Covered	1 per consecutive 60 months
D2961	labial veneer (resin laminate) - laboratory	50%	Not Covered	1 per consecutive 60 months
D2962	labial veneer (porcelain laminate) - laboratory	50%	Not Covered	1 per consecutive 60 months
D2975	coping	50%	Not Covered	1 per consecutive 60 months
D2980	crown repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2981	inlay repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2982	onlay repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	Not Covered	Unlimited
Endodontics				
D3110	pulp cap - direct (excluding final restoration)	50%	Not Covered	No frequency limitation
D3120	pulp cap - indirect (excluding final restoration)	50%	Not Covered	No frequency limitation
D3220	therapeutic pulpotomy (excluding final restoration)	50%	Not Covered	1 time per primary or

MediGold Dental Gold				
				secondary tooth per lifetime
D3221	pulpal debridement, primary and permanent teeth	50%	50%	1 per tooth per lifetime
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	Not Covered	1 time per primary or secondary tooth per lifetime
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	50%	Not Covered	1 time per tooth per lifetime. Covered for anterior or posterior teeth only
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	Not Covered	1 time per tooth per lifetime. Covered for anterior or posterior teeth only
D3310	endodontic therapy, anterior tooth (excluding final restoration)	50%	Not Covered	1 time per tooth per lifetime
D3320	endodontic therapy, premolar tooth (excluding final restoration)	50%	Not Covered	1 time per tooth per lifetime
D3330	endodontic therapy, molar tooth (excluding final restoration)	50%	Not Covered	1 time per tooth per lifetime
D3331	treatment of root canal obstruction, non-surgical access	50%	Not Covered	1 time per tooth per lifetime
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	Not Covered	1 time per tooth per lifetime
D3333	internal tooth repair of performation defects	50%	Not Covered	1 time per tooth per lifetime
D3346	retreatment of previous root canal therapy - anterior	50%	Not Covered	1 time per tooth per lifetime
D3347	retreatment of previous root canal therapy - bicuspid	50%	Not Covered	1 time per tooth per lifetime
D3348	retreatment of previous root canal therapy - molar	50%	Not Covered	1 time per tooth per lifetime
D3351	Apexification/recalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc	50%	Not Covered	1 time per tooth per lifetime

MediGold Dental Gold				
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	50%	Not Covered	1 time per tooth per lifetime
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	50%	Not Covered	1 time per tooth per lifetime
D3355	Pupal regeneration-initial visit	50%	Not Covered	1 time per tooth per lifetime
D3356	Pulpal regeneration-interim medicament replacement	50%	Not Covered	1 time per tooth per lifetime
D3357	Pulpal regeneration-completion of treatment	50%	Not Covered	1 time per tooth per lifetime
D3410	Apicoectomy - anterior	50%	Not Covered	1 time per tooth per lifetime
D3421	Apicoectomy - premolar (first root)	50%	Not Covered	1 time per tooth per lifetime
D3425	Apicoectomy - molar (first root)	50%	Not Covered	1 time per tooth per lifetime
D3426	Apicoectomy (each additional root)	50%	Not Covered	2 times per tooth per lifetime
D3430	retrograde filling - per root	50%	Not Covered	1 time per tooth per lifetime
D3450	root amputation - per root	50%	Not Covered	1 time per tooth per lifetime
D3470	intentional reimplantation (including necessary splinting)	50%	Not Covered	1 time per tooth per lifetime
D3471	surgical repair of root resorption - anterior	50%	Not Covered	1 time per tooth per lifetime
D3472	surgical repair of root resorption – premolar	50%	Not Covered	1 time per tooth per lifetime
D3473	surgical repair of root resorption – molar	50%	Not Covered	1 time per tooth per lifetime
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	50%	Not Covered	2 times per tooth per lifetime
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	50%	Not Covered	2 times per tooth per lifetime
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	50%	Not Covered	2 times per tooth per lifetime

MediGold Dental Gold				
D3911	intraoffice barrier	50%	Not Covered	Unlimited
D3920	hemisection (including any root removal), not including root canal therapy	50%	Not Covered	1 time per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	50%	Not Covered	Unlimited
Periodontics				
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4230	anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4231	anatomical crown exposure - one to three teeth or bounded tooth spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4240	gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4241	gingival flap procedure - including root planing -one to three contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4245	apically positioned flap	50%	Not Covered	1 per consecutive 36 months
D4249	clinical crown lengthening - hard tissue	50%	Not Covered	1 per consecutive 36 months
D4260	osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4261	osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	Not Covered	1 per consecutive 36 months
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	50%	Not Covered	1 per consecutive 36 months

MediGold Dental Gold				
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	50%	Not Covered	1 per consecutive 36 months
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	50%	Not Covered	1 per consecutive 36 months
D4266	guided tissue regeneration - resorbable barrier, per site	50%	Not Covered	1 per consecutive 36 months
D4267	guided tissue regeneration - nonresorbable barrier, per site (Includes membrane removal)	50%	Not Covered	1 per consecutive 36 months
D4268	surgical revision procedure, per tooth	50%	Not Covered	1 per consecutive 36 months
D4270	pedicle soft tissue graft procedure	50%	Not Covered	1 per consecutive 36 months
D4273	autogenous connective tissue graft procedure, per first tooth, implant or endentulous tooth position in graft	50%	Not Covered	1 per consecutive 36 months
D4274	mesial/distal wedge procedure single tooth(when not performed in conjunction with surgical procedures in the same area	50%	Not Covered	1 per consecutive 36 months
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth implant	50%	Not Covered	1 per consecutive 36 months
D4276	combined connective tissue and pedicle graft, per tooth	50%	Not Covered	1 per consecutive 36 months
D4277	free soft tissue graft procedure (including recipient and donor surgical sites)first tooth, implant, or edentulous tooth	50%	Not Covered	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	50%	Not Covered	1 per consecutive 36 months
D4283	autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months
D4285	non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	Not Covered	1 per consecutive 36 months

MediGold Dental Gold				
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	50%	Not Covered	1 per consecutive 36 months
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	50%	Not Covered	1 per consecutive 36 months
D4341	periodontal scaling and root planing - four or more teeth per quadrant	50%	Not Covered	1 time per quadrant per consecutive 24 months
D4342	periodontal scaling and root planing - one - three teeth, per quadrant	50%	Not Covered	1 time per quadrant per consecutive 24 months
D4346	scaling in presence of generalized moderate or severe gingival inflammation	50%	Not Covered	2 times per consecutive 12 months.
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	50%	Not Covered	1 per consecutive 36 months
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%	Not Covered	3 sites per quadrant or 12 sites total per lifetime for refractory pockets or in conjunction with Periodontal Scaling and Root Planing
D4910	periodontal maintenance	50%	Not Covered	2 per calendar year following active or adjunctive periodontal therapy, exclusive of gross debridement.
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	50%	Not Covered	No frequency limitation
D4999	Unspecified periodontal procedure, by report	50%	Not Covered	Unlimited
Dentures				
D5110	complete denture - maxillary	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D5120	complete denture - mandibular	50%	Not Covered	1 per consecutive 60 months
D5130	immediate denture - maxillary	50%	Not Covered	1 per consecutive 60 months
D5140	immediate denture - mandibular	50%	Not Covered	1 per consecutive 60 months
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	50%	Not Covered	1 per consecutive 60 months
D5212	mandibular partial denture - resin base (including any conventional clasps,rests and teeth)	50%	Not Covered	1 per consecutive 60 months
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	50%	Not Covered	1 per consecutive 60 months
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	50%	Not Covered	1 per consecutive 60 months
D5221	immediate maxillary partial denture - resin base	50%	Not Covered	1 per consecutive 60 months
D5222	immediate mandibular partial denture - resin base	50%	Not Covered	1 per consecutive 60 months
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases	50%	Not Covered	1 per consecutive 60 months
D5224	immediate mandibular partial denture-cast metal framework with resin denture bases	50%	Not Covered	1 per consecutive 60 months
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	Not Covered	1 per consecutive 60 months
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	Not Covered	1 per consecutive 60 months
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	Not Covered	1 per consecutive 60 months
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D5282	removable unilateral partial denture – one-piece cast metal (including clasps and teeth), maxillary. D5283 removable unilateral partial denture – one-piece cast metal (including clasps and teeth), mandibular	50%	Not Covered	1 per consecutive 60 months
D5283	removable unilateral partial denture – one-piece cast metal (including clasps and teeth), mandibular	50%	Not Covered	1 per consecutive 60 months
D5284	removable unil. part denture – one piece flex. base (incl. retentive/clasping materials, rests, and teeth), per quadrant	50%	Not Covered	1 per consecutive 60 months
D5286	removable unil. part denture – one piece resin (incl. retentive/clasping materials, rests, and teeth), per quadrant	50%	Not Covered	1 per consecutive 60 months
D5410	adjust complete denture - maxillary	50%	Not Covered	1 per consecutive 6 months
D5411	adjust complete denture - mandibular	50%	Not Covered	1 per consecutive 6 months
D5421	adjust partial denture - maxillary	50%	Not Covered	1 per consecutive 6 months
D5422	adjust partial denture - mandibular	50%	Not Covered	1 per consecutive 6 months
D5511	repair broken complete denture base, mandibular	50%	Not Covered	1 per consecutive 6 months
D5512	repair broken complete denture base, maxillary	50%	Not Covered	1 per consecutive 6 months
D5520	replace missing or broken teeth - complete denture (each tooth)	50%	Not Covered	1 per consecutive 6 months
D5611	repair resin partial denture base, mandibular	50%	Not Covered	1 per consecutive 6 months
D5612	repair resin partial denture base, maxillary	50%	Not Covered	1 per consecutive 6 months
D5621	repair cast partial framework, mandibular	50%	Not Covered	1 per consecutive 6 months
D5622	repair cast partial framework, maxillary	50%	Not Covered	1 per consecutive 6 months
D5630	repair or replace broken clasp - per tooth	50%	Not Covered	1 per consecutive 6 months
D5640	replace broken teeth - per tooth	50%	Not Covered	1 per consecutive 6 months

MediGold Dental Gold				
D5650	add tooth to existing partial denture	50%	Not Covered	1 per consecutive 6 months
D5660	add clasp to existing partial denture - per tooth	50%	Not Covered	1 per consecutive 6 months
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	50%	Not Covered	1 per consecutive 6 months
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	50%	Not Covered	1 per consecutive 6 months
D5710	rebase complete maxillary denture	50%	Not Covered	1 per consecutive 12 months
D5711	rebase complete mandibular denture	50%	Not Covered	1 per consecutive 12 months
D5720	rebase maxillary partial denture	50%	Not Covered	1 per consecutive 12 months
D5721	rebase mandibular partial denture	50%	Not Covered	1 per consecutive 12 months
D5725	rebase hybrid prosthesis	50%	Not Covered	1 per consecutive 12 months
D5730	reline complete maxillary denture (chairside)	50%	Not Covered	1 per consecutive 12 months
D5731	reline complete mandibular denture (chairside)	50%	Not Covered	1 per consecutive 12 months
D5740	reline maxillary partial denture (chairside)	50%	Not Covered	1 per consecutive 12 months
D5741	reline mandibular partial denture (chairside)	50%	Not Covered	1 per consecutive 12 months
D5750	reline complete maxillary denture (laboratory)	50%	Not Covered	1 per consecutive 12 months
D5751	reline complete mandibular denture (laboratory)	50%	Not Covered	1 per consecutive 12 months
D5760	reline maxillary partial denture (laboratory)	50%	Not Covered	1 per consecutive 12 months
D5761	reline mandibular partial denture (laboratory)	50%	Not Covered	1 per consecutive 12 months
D5765	soft liner for complete or partial removable denture – indirect	50%	Not Covered	1 per consecutive 12 months
D5810	interim complete denture (maxillary)	50%	Not Covered	1 per consecutive 60 months
D5811	interim complete denture (mandibular)	50%	Not Covered	1 per consecutive 60 months
D5820	interim partial denture (maxillary)	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D5821	interim partial denture (mandibular)	50%	Not Covered	1 per consecutive 60 months
D5850	tissue conditioning, maxillary	50%	Not Covered	1 per consecutive 12 months
D5851	tissue conditioning, mandibular	50%	Not Covered	1 per consecutive 12 months
D5863	Overdenture-complete maxillary	50%	Not Covered	1 per consecutive 60 months
D5864	Overdenture-partial maxillary	50%	Not Covered	1 per consecutive 60 months
D5865	Overdenture - complete mandibular	50%	Not Covered	1 per consecutive 60 months
D5866	Overdenture-partial mandibular	50%	Not Covered	1 per consecutive 60 months
Crowns & Bridges				
D6205	pontic - indirect resin based composite	50%	Not Covered	1 per consecutive 60 months
D6210	pontic - cast high noble metal	50%	Not Covered	1 per consecutive 60 months
D6211	pontic - cast predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6212	pontic - cast noble metal	50%	Not Covered	1 per consecutive 60 months
D6214	pontic - titanium	50%	Not Covered	1 per consecutive 60 months
D6240	pontic - porcelain fused to high noble metal	50%	Not Covered	1 per consecutive 60 months
D6241	pontic - porcelain fused to predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6242	pontic - porcelain fused to noble metal	50%	Not Covered	1 per consecutive 60 months
D6243	pontic - porcelain fused to titanium and titanium alloys	50%	Not Covered	1 per consecutive 60 months
D6245	pontic-porcelain/ceramic	50%	Not Covered	1 per consecutive 60 months
D6250	pontic - resin with high noble metal	50%	Not Covered	1 per consecutive 60 months
D6251	pontic - resin with predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6252	pontic - resin with noble metal	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D6253	interim pontic - further treatment or completion of diagnosis necessary prior to final impression	50%	Not Covered	1 per consecutive 60 months
D6545	retainer - cast metal for resin bonded fixed prosthesis	50%	Not Covered	1 per consecutive 60 months
D6548	retainer-porcelain/ceramic for resin bonded fixed prosthesis	50%	Not Covered	1 per consecutive 60 months
D6549	resin retainer - for resin bonded fixed prosthesis	50%	Not Covered	1 per consecutive 60 months
D6600	retainer inlay-porcelain/ceramic, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6602	retainer inlay - cast high noble metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6603	retainer inlay - cast high noble metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6604	retainer inlay - cast predominantly base metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6606	retainer inlay - cast noble metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6607	retainer inlay - cast noble metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6608	retainer onlay - porcelain/ceramic, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6609	retainer onlay - porcelain/ceramic, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6610	retainer onlay - cast high noble metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6611	retainer onlay - cast high noble metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6612	retainer onlay - cast predominantly base metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months
D6614	retainer onlay - cast noble metal, two surfaces	50%	Not Covered	1 per consecutive 60 months
D6615	retainer onlay - cast noble metal, three or more surfaces	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D6624	retainer inlay - titanium	50%	Not Covered	1 per consecutive 60 months
D6634	retainer onlay - titanium	50%	Not Covered	1 per consecutive 60 months
D6710	retainer crown - indirect resin based composite (not to be used as a temporary or provisional crown)	50%	Not Covered	1 per consecutive 60 months
D6720	retainer crown - resin with high noble metal	50%	Not Covered	1 per consecutive 60 months
D6721	retainer crown - resin with predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6722	retainer crown - resin with noble metal	50%	Not Covered	1 per consecutive 60 months
D6740	retainer crown-porcelain/ceramic	50%	Not Covered	1 per consecutive 60 months
D6750	retainer crown - porcelain fused to high noble metal	50%	Not Covered	1 per consecutive 60 months
D6751	retainer crown - porcelain fused to predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6752	retainer crown - porcelain fused to noble metal	50%	Not Covered	1 per consecutive 60 months
D6753	retainer crown - porcelain fused to titanium and titanium alloys	50%	Not Covered	1 per consecutive 60 months
D6780	retainer crown - 3/4 cast high noble metal	50%	Not Covered	1 per consecutive 60 months
D6781	retainer crown-3/4 cast predominately based metal	50%	Not Covered	1 per consecutive 60 months
D6782	retainer crown-3/4 cast noble metal	50%	Not Covered	1 per consecutive 60 months
D6783	retainer crown-3/4 porcelain/ceramic	50%	Not Covered	1 per consecutive 60 months
D6784	retainer crown 3/4 - titanium and titanium alloys	50%	Not Covered	1 per consecutive 60 months
D6790	retainer crown - full cast high noble metal	50%	Not Covered	1 per consecutive 60 months
D6791	retainer crown - full cast predominantly base metal	50%	Not Covered	1 per consecutive 60 months
D6792	retainer crown - full cast noble metal	50%	Not Covered	1 per consecutive 60 months
D6793	interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	50%	Not Covered	1 per consecutive 60 months

MediGold Dental Gold				
D6794	retainer crown - titanium	50%	Not Covered	1 per consecutive 60 months
D6930	recement or re-bond fixed partial denture	0%	Not Covered	1 per consecutive 6 months
D6980	fixed partial denture repair, necessitated by restorative material failure	50%	Not Covered	1 per consecutive 6 months
Oral & Maxillofacial Surgery				
D7111	extraction, coronal remnants - primary tooth	50%	Not Covered	1 time per tooth per lifetime
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%	Not Covered	1 time per tooth per lifetime
D7210	extraction, erupted tooth req removal of bone,sectioning of tooth and including elevation of mucoperiosteal flap	50%	Not Covered	1 time per tooth per lifetime
D7220	removal of impacted tooth - soft tissue	50%	Not Covered	1 time per tooth per lifetime
D7230	removal of impacted tooth - partially bony	50%	Not Covered	1 time per tooth per lifetime
D7240	removal of impacted tooth - completely bony	50%	Not Covered	1 time per tooth per lifetime
D7241	removal of impacted tooth - completely bony, with unusual surgical	50%	Not Covered	1 time per tooth per lifetime
D7250	removal of residual tooth roots (cutting procedure)	50%	Not Covered	1 time per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	Not Covered	Unlimited
D7260	oroantral fistula closure	50%	Not Covered	1 per site per visit
D7261	primary closure of a sinus perforation	50%	Not Covered	1 time per lifetime
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	Not Covered	1 time per site per lifetime
D7272	tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	50%	Not Covered	1 time per tooth per lifetime
D7280	exposure of an unerupted tooth	50%	Not Covered	1 time per tooth per lifetime

MediGold Dental Gold				
D7282	mobilization of erupted or malpositioned tooth to aid eruption	50%	Not Covered	1 time per tooth per lifetime
D7283	placement of device to facilitate eruption of impacted tooth	50%	Not Covered	1 time per tooth per lifetime
D7285	incisional biopsy of oral tissue - hard (bone, tooth)	50%	Not Covered	1 biopsy per site per visit
D7286	incisional biopsy of oral tissue - soft (all others)	50%	Not Covered	1 biopsy per site per visit
D7287	exfolliative cytological sample collection	50%	Not Covered	1 biopsy per site per visit
D7288	brush biopsy - transepithelial sample collection	50%	Not Covered	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	Not Covered	Unlimited
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	50%	Not Covered	1 time per tooth per lifetime
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	Not Covered	No frequency limitation
D7311	alveoplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	50%	Not Covered	No frequency limitation
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	Not Covered	No frequency limitation
D7321	alveoplasty not in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	50%	Not Covered	No frequency limitation
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	50%	Not Covered	1 per consecutive 60 months
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment	50%	Not Covered	1 per consecutive 60 months
D7410	excision of benign lesion up to 1.25 cm	50%	Not Covered	1 per site per visit
D7411	excision of benign lesion greater than 1.25 cm	50%	Not Covered	1 per site per visit
D7412	excision of benign lesion, complicated	50%	Not Covered	1 per site per visit
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%	Not Covered	1 per site per visit

MediGold Dental Gold				
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%	Not Covered	1 per site per visit
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%	Not Covered	1 per site per visit
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%	Not Covered	1 per site per visit
D7472	removal of torus palatinus	50%	Not Covered	1 per site per visit
D7473	removal of torus mandibularis	50%	Not Covered	1 per site per visit
D7510	incision and drainage of abscess - intraoral soft tissue	50%	Not Covered	1 per site per visit
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	Not Covered	1 per site per visit
D7520	incision and drainage of abscess - extraoral soft tissue	50%	Not Covered	1 per site per visit
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	Not Covered	1 per site per visit
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	50%	Not Covered	1 per site per visit
D7540	removal of reaction-producing foreign bodies - musculoskeletal system	50%	Not Covered	1 per site per visit
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	50%	Not Covered	1 per site per visit
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	50%	Not Covered	1 per site per visit
D7881	occlusal orthotic device adjustment	50%	Not Covered	1 per consecutive 6 months
D7910	Suture of recent small wounds up to 5 cm	50%	Not Covered	Unlimited
D7953	Bone replacement graft for ridge preservation - per site	50%	Not Covered	1 per site per lifetime
D7961	buccal / labial frenectomy (frenulectomy)	50%	Not Covered	No frequency limitation
D7962	lingual frenectomy (frenulectomy)	50%	Not Covered	No frequency limitation

MediGold Dental Gold				
D7963	frenuloplasty	50%	Not Covered	No frequency limitation
D7970	excision of hyperplastic tissue - per arch	50%	Not Covered	1 per site per consecutive 36 months
D7971	excision of pericoronal gingiva	50%	Not Covered	1 per site per consecutive 36 months
D7972	surgical reduction of fibrous tuberosity	50%	Not Covered	No frequency limitation
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	50%	Not Covered	1 per appliance per lifetime
D7999	Unspecified oral surgery procedure, by report	50%	Not Covered	Unlimited
Adjunctive General Services				
D9110	palliative (emergency) treatment of dental pain - minor procedure	0%	0%	No frequency limitation
D9120	fixed partial denture sectioning	0%	Not Covered	1 per consecutive 60 months
D9210	local anesthesia not in conjunction with operative or surgical procedures	0%	Not Covered	No frequency limitation
D9215	local anesthesia in conjunction with operative or surgical procedures	0%	Not Covered	No frequency limitation
D9219	evaluation for deep sedation or general anesthesia	0%	Not Covered	4 times per consecutive 12 months
D9222	deep sedation/general anesthesia - first 15 minutes	0%	Not Covered	No frequency limitation
D9223	deep sedation/general anesthesia-each subsequent 15 minute increment	0%	Not Covered	No frequency limitation
D9230	inhalation of nitrous oxide/anxiolysis analgesia	0%	Not Covered	No frequency limitation
D9239	intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	0%	Not Covered	No frequency limitation
D9243	intravenous moderate (conscious) sedation/analgesia-each subsequent 15 minute increment	0%	Not Covered	No frequency limitation
D9248	non-intravenous conscious sedation. This includes non-iv minimal and moderate sedation.	0%	Not Covered	No frequency limitation

MediGold Dental Gold				
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	0%	Not Covered	4 per consecutive 12 months
D9610	therapeutic parenteral drug, single administration	0%	Not Covered	1 per visit
D9612	therapeutic parenteral drugs, two or more administrations, different medications	0%	Not Covered	1 per visit
D9630	drugs orbmedicaments, dispensed in the office for home use	0%	Not Covered	1 per visit
D9910	application of desensitizing medicament	0%	Not Covered	No frequency limitation
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	0%	Not Covered	No frequency limitation
D9912	pre-visit patient screening	0%	Not Covered	2 per calendar year
D9942	repair and/or reline of occlusal guards	0%	Not Covered	1 per consecutive 12 months
D9943	occlusal adjustment	0%	Not Covered	1 per consecutive 6 months
D9944	occlusal guard - hard appliance, full arch	0%	Not Covered	1 per site per consecutive 36 months
D9945	occlusal guard - soft appliance, full arch	0%	Not Covered	1 per site per consecutive 36 months
D9946	occlusal guard - hard appliance, partial arch	0%	Not Covered	1 per site per consecutive 36 months
D9947	custom sleep apnea appliance fabrication and placement	0%	Not Covered	1 per site per consecutive 36 months
D9948	adjustment of custom sleep apnea appliance	0%	Not Covered	1 per consecutive 6 months
D9949	repair of custom sleep apnea appliance	0%	Not Covered	1 per consecutive 12 months
D9950	occlusion analysis - mounted case	0%	Not Covered	1 per consecutive 60 months
D9951	occlusal adjustment - limited	0%	Not Covered	No frequency limitation

MediGold Dental Gold				
D9952	occlusal adjustment - complete	0%	Not Covered	No frequency limitation
D9995	teledentistry - synchronous; real-time encounter	0%	0%	2 per calendar year
D9996	teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review	0%	0%	2 per calendar year

DENTAL LIMITATIONS & EXCLUSIONS

LIMITATIONS	
1.	Dental services are covered at the least costly, clinically accepted treatment. The following benefits are automatically covered under an Alternate Benefit:Posterior Composites, Gold Foil Restorations, Metallic, Porcelain/Ceramic, and Resin-based Composite Inlays alt benefit to Amalgam Fillings Porcelain/Ceramic Onlays alt benefit to Metallic Onlays High Noble, Porcelain, Porcelain/Ceramic or Titanium Crowns, Inlays, Onlays and Pontics alt benefit to noble metal Crowns, Inlays, Onlays and Pontics Resin-based Composite Crowns alt benefit to a provisional crown Post and Cores alt benefit to Prefabricated Post and Cores Manually alt benefited services are listed under Utilization Review in Section 1.
2.	Oral Evaluations (D0120-D0170, D0180) are limited to 2 times per 12 consecutive months.
3.	Intraoral-Complete Series, Vertical Bitewings and Panorex Radiographs (D0210, D0277 and D0330) are limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.
4.	Intraoral – Periapical radiographs (D0220, D0230) are limited to a total of 8 films per plan year. Intraoral – Occlusal radiograph (D0240) is limited to 2 per consecutive 6 months.
5.	Extra-oral Radiographs (D0250 and D0251) are limited to 2 films per plan year.
6.	Bitewing Radiographs (D0270, D0272, D0273 and D0274) are limited to 1 series of films per plan year.
7.	Oral/Facial Photographic Image Obtained Intraorally or Extraorally (D0350-D0351) is limited to 1 time per consecutive 36 months.
8.	Cone Beams (D0364-D0367) are limited to 1 time per consecutive 60 months and are covered in Major Services.
9.	Oral Cancer Screening (Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures) (D0431) is limited to 1 time per consecutive 12 months.
10.	Pulp Vitality Tests (D0460) is limited to 1 charge per visit regardless of how many teeth are tested.

11.	Diagnostic Casts (D0470) are limited to 1 time per consecutive 24 months.
12.	Dental Prophylaxis (D1110 and D1120) is limited to 2 times per 12 consecutive months. Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (D4346) is limited to 2 times per 12 months.
13.	Multiple Restorations on 1 surface (D2140, D2330 and D2391) will be treated as a single filling. *D2391 Alt Benefits as per Section 7.1
14.	Inlays* (D2510 – D2530, D2610 – D2630, D2650 – D2652) & Onlays (D2542 – D2544, D2642* – D2644*, D2662 – D2664) are limited to 1 time per 60 consecutive months. Covered only when a filling cannot restore the tooth; not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. *D2510 – D2530, D2610 – D2630, D2650 – D2652 & D2642 – D2644 Alt Benefited as per Section 7.1
15.	Recement Inlays/Onlays (D2910), Crowns (D2920), Bridges (D6930) and Post and Core (D2915) are limited to those performed more than 12 months after the initial insertion. Recements of inlays, onlays, post and cores and crowns are limited to 1 time per consecutive 12 months. Recements of bridges are limited to 1 time per consecutive 6 months.
16.	Crowns (D2390, D2710 - D2792, D2794, D2799 and D2930-D2933) are limited to 1 per consecutive 60 months. Covered only when a filling cannot restore the tooth; not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes. Prefabricated Esthetic Coated Stainless Steel Crown (D2934) is limited to primary anterior teeth and has a frequency limit of 1 per consecutive 60 months. (Tooth Range C-H and M-R). *D2710, D2720, D2740, D2750, D2780, D2783, D2790 & D2794 Alt Benefit as per Section 7.1
17.	Posts and Cores (D2952 – D2954, D2957) are covered only for teeth that have had root canal therapy. Limited to 1 per 60 consecutive months. *D2952 & D2953 Alt Benefit as per Section 7.1
18.	Protective Restorations (D2940) are covered as a separate benefit only if no other service other than X-rays and exam, were done on the same tooth during the visit.
19.	Core Buildup, including any pins when required (D2950) is limited to 1 per consecutive 60 months.
20.	Pin Retention (D2951) is not covered in addition to Cast Restoration. Cast Restoration is defined as inlays and onlays. Limited to 1 time per consecutive 60 months.
21.	Labial Veneers (D2960-D2962) are limited to 1 per consecutive 60 months.
22.	Coping (D2975) is limited to 1 per tooth per consecutive 60 months and is not covered if done at the same time as a crown on the same tooth.
23.	Pulp Caps–Direct/Indirect-excluding final restoration (D3110 and D3120) are not covered if utilized solely as a liner or base underneath a restoration.
24.	Therapeutic Pulpotomy (D3220) is limited to 1 time per primary or secondary tooth per lifetime. Pulpal Therapy/Resorbable Filling (D3230 and D3240) is limited to 1 time per tooth per lifetime; covered for anterior or posterior teeth only.

25.	Pulpal Debridement and Partial Pulpotomy for Apexogenesis (D3221 and D3222) are limited to 1 time per tooth per lifetime. Not covered on the same day as other endodontic services.
26.	Root Canal Therapy (D3310 - D3333) is limited to 1 per tooth per lifetime. The dentist who performed the original root canal should not be reimbursed for the retreatment (D3346, D3347, D3348) for the first 12 months. Retreatment of Root Canals is limited to 1 time per lifetime.
27.	Apexification (D3351, D3352, D3353), Pulpal Regeneration (D3355, D3356, D3357) Apicoectomy (D3410, D3421, D3425), Retrograde filling (D3430), Root Resection/Amputation (D3450) are limited to 1 time per tooth per lifetime. Apicoectomy – each additional root (D3426) and periradicular surgery without apicoectomy (D3427) is limited to 2 times per tooth per lifetime.
28.	Hemisection (D3920) is limited to 1 time per tooth per lifetime.
29.	Crown Lengthening (D4249), Gingivectomy/Gingivoplasty (D4210, D4211), Anatomical Crown Exposure (D4230, D4231), Gingival Flap Procedure (D4240, D4241, D4245), Osseous Graft (D4263, D4264, D4265), Osseous Surgery (D4260, D4261), Guided Tissue Regeneration (D4266, D4267), Soft Tissue Surgery (D4270, D4273, D4274, D4275, D4276, D4277; D4283, D4285) are limited to 1 per quadrant or site per consecutive 36 months. Provisional Splinting (D4320, D4321) is limited to 1 per consecutive 36 months and cannot be used to restore vertical dimension or as part of full mouth rehabilitation; should not include use of laboratory based crowns and/or fixed partial dentures (bridges); exclusion of laboratory based crowns or bridges for the purposes of provisional splinting. (D4346 is listed with Prophy, see D1110 & D1120 above)
30.	Surgical Revision Procedure (D4268) is limited to 1 per consecutive 36 months
31.	Scaling and Root Planing (D4341 and D4342) are limited to 1 time per quadrant per consecutive 24 months.
32.	Full Mouth Debridement (D4355) is limited to 1 time per consecutive 36 months.
33.	Localized Delivery of Antimicrobial Agents (D4381) is limited to 3 sites per quadrant or 12 sites total per lifetime for refractory pockets or in conjunction with Periodontal Scaling and Root Planing (D4341 and D4342).
34.	Periodontal Maintenance (D4910) is limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement (D4355).
35.	Complete Dentures (D5110 and D5120), Immediate Dentures (D5130) and D5140), Interim Complete Dentures (D5810 and D5811) and Overdentures (D5863, D5865) are limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
36.	Partial Dentures (D5211-D5286), Interim Partial Dentures (D5820 and D5821), Fixed Partial Denture Pontics (D6205-D6253), Interim Pontic D6254), Fixed Partial Denture Retainers-Inlays/Onlays (D6545-D6634) and Fixed Partial Denture Retainer Crowns (D6710-D6794, Fixed Partial Denture Sectioning D9120 & Overdentures D5864 &D5866

	are limited to 1 per consecutive 60 months. There are no additional allowances for precision or semi precision attachments (D5862, D5867, D6950). *The following Alt Benefit per 7.1: D6210, D6214, D6240, D6243, D6245, D6250, D6548, D6600 – D6603, D6608 – D6611, D6624, D6634, D6720, D6740, D6750, D6753, D6780, D6783, D6784, D6790 & D6794.
37.	Repairs and Adjustments to Full Dentures (D5410, D5411, D5511-D5512 and D5520) or Partial Fixed or Removable Dentures (D5421, D5422, D5611-D5612, D5621-D5622, D5630-D5671 and D6980 and Crowns/Inlay/Onlay (D2980-D2982) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months. Reattachment of tooth fragment, incisal edge or cusp (D2921) is limited to 1 per consecutive 6 months.
38.	Relining and Rebasing Dentures (D5710 – D5761) is limited to relining/rebasing performed more than 6 months after the initial insertions. Limited to 1 time per consecutive 12 months. Add metal substructure to acrylic full denture (D5876) is limited to 1 time per consecutive 12 months.
39.	Tissue Conditioning – Maxillary or Mandibular (D5850 and D5851) is limited to 1 per consecutive 12 months.
40.	Simple Extractions (D7111, D7140), Extraction of Erupted Tooth (D7210), Surgical Extraction of Impacted Teeth (D7220, D7230, D7240, D7241) Root Removal (D7250) are limited to 1 time per tooth per lifetime.
41.	Oroantral Fistula Closure (D7260) is limited to 1 per site per visit.
42.	Primary Closure of a Sinus Perforation (D7261), Placement of Device to Facilitate Eruption of Impacted Tooth (D7283) and Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report (D7291) are limited to 1 per tooth per lifetime.
43.	Tooth Reimplantation and/or Transplantation Services (D3470, D7270 and D7272) are limited to 1 per site per lifetime.
44.	Exposure of an Unerupted Tooth (D7280) is limited to 1 time per tooth per lifetime.
45.	Mobilization of erupted or malpositioned tooth to aid eruption (D7282) is limited to 1 time per tooth per lifetime.
46.	Biopsy (D7285-D7288) is limited to 1 biopsy per site per visit.
47.	Vestibuloplasty (D7340 and D7350) is limited to 1 time per site per consecutive 60 months.
48.	Removal of a Benign Cyst/Lesion (D7410–D7412, D7450-D7461) is limited to 1 per site per visit.
49.	Removal of Torus (D7472 and D7473) is limited to 1 per site per visit.
50.	Surgical Incision (D7510-D7560) is limited to 1 time per site per visit.

51.	Bone Replacement Graft for Ridge Preservation – per site (D7953) is limited to 1 per site per lifetime and is not covered if done in conjunction with other bone graft replacement procedures.
52.	Excision of Hyperplastic Tissue or Pericoronal Gingivia (D7970 and D7971) is limited to 1 per site per consecutive 36 months.
53.	Appliance Removal (D7997) is limited to once per appliance per lifetime; includes removal of arch bar. Not covered if performed by the dentist who placed the appliance.
54.	Palliative Treatment (D9110) is covered as a separate benefit only if no other service, other than radiographs and exam, were done on the same tooth during the visit.
55.	Deep Sedation/General Anesthesia (D9223) Analgesia (D9230), Intravenous Moderate Sedation and Analgesia (D9243), Deep sedation/general anesthesia – first 15 minutes (D9222), intravenous moderate (conscious) sedation/anesthesia – first 15 minutes (D9239) and Non-Intravenous Conscious Sedation (D9248) are covered when necessary in conjunction with covered dental services; if required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over age of 6 if it is clinically necessary (refer to Section 9). Evaluation for deep sedation or general anesthesia (D9219) Limitation of 4 evaluations per consecutive12 months
56.	Consultation (D9310) is limited to 4 per consecutive 12 months.
57.	Occlusal Guards (D9944-D9946) are covered only if prescribed to control habitual grinding and are limited to 1 guard per consecutive 36 months. Occlusal Analysis – mounted case (D9950) is limited to 1 per consecutive 60 months.
58.	Occlusal Guard Reline and Repair (D9942) MUST be performed more than 6 months after initial insertion and is limited to 1 time per consecutive 12 months. Occlusal Guard Adjustments (D9943) are limited to those done more than 12 months after the initial insertion and limited to 1 per consecutive 6 months.
59.	Teledentistry (D9995-D9996) is limited to 2 times per 12 consecutive months.

EXCLUSIONS	
1.	Dental Services that are not necessary.
2.	Hospitalization or other facility charges.
3.	Any dental procedure performed solely for cosmetic/aesthetic reasons. Cosmetic procedures are those procedures that improve physical appearance.
4.	Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5.	Any dental procedure not directly associated with dental disease.

6.	Any procedure not performed in a dental setting.
7.	Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8.	Services for injuries or conditions covered by Worker's Compensation or employer liability laws and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9.	Expenses for dental procedures that began prior to the Covered Person becoming enrolled under the Policy.
10.	Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11.	Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12.	Foreign services are not covered unless required as an emergency.
13.	Replacement of crowns, bridges, dentures, fixed or removable prosthetic appliances and implants, implant crowns and prosthesis inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition. NOTE: This Exclusion does NOT apply if the plan has NO waiting periods for Class III services or if the member has their waiting period waived.
14.	Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months. NOTE: This Exclusion does NOT apply if the plan has NO waiting periods for Class III services or if the member has their waiting period waived.
15.	Replacement of complete dentures, fixed and removable partial dentures, crowns or implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
16.	Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
17.	Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant

	prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18.	Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).
19.	Placement of dental implants, implant-supported abutments and prostheses (D6010; D6012-D3019; D6021-D6052 D6055-D6077; D6080-D6199). NOTE: This Exclusion does NOT apply if implant coverage is indicated.
20.	Placement of fixed partial dentures (D6205 – D6793, D6920) solely for the purpose of achieving periodontal stability.
21.	Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital malformations of hard or soft tissue, including excision (D7413-D7415, D7440-D7441, D7490).
22.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue (D7610 – D7780).
23.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral (D7810 – D7899). Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery (D7920-D7949), jaw alignment, or treatment for the temporomandibular joint. NOTE: This Exclusion does NOT apply if TMJ coverage is indicated.
24.	Acupuncture; acupressure and other forms of alternative treatment whether or not used as anesthesia.
25.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
26.	Occlusal guards (D9941) used as safety items or to affect performance primarily in sports-related activities.
27.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
28.	Local Anesthesia (D9215) is not covered in conjunction with operative or surgical procedures.
29.	Consultation (D9310) is not covered if done with exams or professional visits (D0120, D0140, D0145, D0150, D0160, D0170 and D0180)
30.	In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
31.	Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
32.	The following exclusion only applies to plans that cover orthodontia: Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

SECTION 1: UTILIZATION REVIEW	
1.	Onlays and Crowns – reviewed for necessity and least costly alternative. This includes exclusion due to placement for cosmetic purposes. Note: If root canal on same tooth is already approved per review, then crown is automatically approved. Requires submission of x-rays.
2.	Crown Build-up. Review for necessity. Denied if adequate tooth structure is present to retain crown or when a crown is not necessary. X-ray required.
3.	Post and Cores. Approved when root canal is performed and there is no reason not to place a crown on the tooth. Denied when the tooth has a poor prognosis and the crown is to be denied (periodontal disease, root fracture, etc.).
4.	Veneers – reviewed for dental necessity and least costly alternative. This includes exclusion due to placement for cosmetic purposes. X-ray required, photo recommended.
5.	Retreatment of Root canals, Apicoectomy/Periadicular Services and Hemisection. Review for clinical necessity.
6.	Periodontal Surgery. Review for dental necessity. Requires submission of probe charting and x-rays. Only D4230 – D4231 & D4249 – D4270; D4272-D4277 require Review. (D4210, D4211, D4240 – D4245 do not require review)
7.	Fixed Partial Denture Services. Review for necessity and least costly alternative. X-rays required.
8.	Anesthesia (D9222, D9223, D9230, D9239, D9243 and D9248) review for clinical necessity. Clinical necessity determined by the type, extent and duration of the service for which anesthesia is being administered. Covered when necessary in conjunction with covered dental services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically necessary. Covered for patients over 6 years of age if it is clinically necessary.
9.	Implants and/or Implant Services (D6010; D6012-D6019; D6021-D6052 D6055-D6077; D6080-D6199). Review for necessity and appropriateness; x- rays and narrative required.
10.	Therapeutic Parenteral Drugs (D9610 & D9612) review for clinical necessity.
11.	Impacted Tooth Extractions. Review for up-coding. X-rays required.

Enrolling in our Optional Supplemental Dental Plans

As a member of our plan, you may voluntarily choose to enroll in one of the Optional Supplemental Dental Plans. The premium for the Dental Silver Plan is **$16**. The premium for the Dental Gold plan is **$34**. You will pay this amount in addition to your Medicare Part B premium and monthly plan premium (if applicable). New members may elect an Optional Supplemental Dental Plan at the time of their enrollment with coverage beginning when they become effective with the plan. Existing members will have the option to elect an Optional Supplemental Dental Plan annually during the Annual Enrollment Period (October 15 through December 7). Coverage for existing members will begin January 1 of the following year.

Disenrolling from our Optional Supplemental Dental Plans

Generally, when you purchase optional supplemental benefits, you continue to receive and pay for them throughout the calendar year. Members may voluntarily drop or discontinue the Optional Supplement Dental benefit at any time during the calendar year by sending the plan written notification in advance of the requested disenrollment date. The notification must be signed by the member and/or authorized representative. Disenrollment will be effective the first day of the month following the receipt of the written notification.

No monthly pro-ration of premiums will be considered. A member who disenrolls from an Optional Supplemental Dental Plan through proper advance notice need not pay further monthly premiums for their dental coverage, however, unpaid past premiums will still be due. Any overpayment for optional supplemental benefits will be applied to your health plan premium account. Please refer to Chapter 1 to learn about our refund policy.

If you are disenrolled from an Optional Supplemental Dental Plan during the year, you must wait until fall to enroll again during the Annual Enrollment Period. For more information about ending your membership, please refer to Chapter 8. Please know that all premiums must be paid current (in full) before we can accept your request to purchase this Optional Supplemental Dental Plan.

If you get behind on your monthly premium payments, future payments will be applied first to the oldest outstanding balances you owe for your health plan premiums. Please keep your payments current to avoid unnecessary inconvenience and confusion. If you do not keep your health plan premiums and Optional Supplemental Dental Plan premiums paid current, it could result in your disenrollment from the plan or reduction in benefits. For example, if your health plan premiums are paid in full but you fail to keep your Optional Supplemental Dental Plan premiums paid current, it could result in the loss of your Optional Supplemental Dental Plan while keeping your health plan coverage. We will send letters to you any time our records indicate you have an outstanding balance on your account.

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

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program outside of the state of Ohio but within the United States and its territories, which will allow you to remain enrolled when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost sharing.

This benefit has an annual coverage maximum of $3,500 per calendar year (amounts do not carry over from year to year) and:

- Members must contact Member Services at 1-800-240-3851 (TTY 711), 8 a.m. - 8 p.m., 7 days a week prior to traveling to initiate the benefit.
- If the benefit is not initiated prior to traveling, member will not be able to access the visitor travel benefit.
- Members may need prior authorization for some services received while using the visitor travel benefit. Covered services that require prior authorization are listed in the Medical Benefits chart found in Chapter 4, Section 2.1.
- The member, or the out-of-state provider, can request prior authorization by calling the number on the back of the member ID card.
- Members are responsible for ensuring prior authorization is in place, if needed prior to rendering services.
- Transportation services are not eligible under the visitor travel benefit.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

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.		✓
Cosmetic surgery or procedures		✓ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care 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.	✓	
Dentures, crowns and bridges.	✓	
Diagnostic services, including X-rays, performed in a chiropractor's office.	✓	
Driving evaluations or driving assessments.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.)
Eyeglasses, radial keratotomy, LASIK surgery and other low vision aids.		✓ One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Coverage for eyeglasses, frames, lenses, or contacts up to the plan allowance amount.
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Hearing aids and provider visits to service hearing aids (except as specifically described in the Medical Benefits Chart), ear molds, hearing aid accessories, return fees, restocking fees, warranty claim fees and hearing aid batteries (beyond the free batteries included per aid purchased).	✓	
Home-delivered meals.		✓

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Injuries received while committing a crime where member is convicted of a criminal felony.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-emergency ambulance services, transport by wheelchair van or ambulette and trips to or from a physician's office and patient convenience transfers between skilled nursing facilities and hospitals, including any transportation, facility or physician charges associated with such.		✓ Non-emergency transportation to plan approved providers and locations only.
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet		✓ Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Over-the-counter allowance.		✓

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.	✓	
Physical exams for the purpose of maintaining or obtaining employment, licenses or insurance for premarital purposes.	✓	
Private duty nurses.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Provider administrative charges that include (but are not limited to) the following: medical records costs associated with providing copies, missed appointments charges, charges associated with completing medical forms and/or filling out prescription requests.	✓	
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings or exams.		✓ Routine dental care provided under the preventive dental benefit.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Scheduled or routine service outside the U.S.	✓	
Services and items that neither the member nor any other party acting by or on behalf of the member has a legal obligation to pay.	✓	
Services and items required by a newborn on the basis of the mother's membership in the plan.	✓	
Services considered not reasonable and necessary, according to Original Medicare standards	✓	
Services ordered or mandated by a court.		✓ Only covered when it's for member protection from physical or mental abuse.
Services provided to veterans in Veterans Affairs (VA) facilities.	✓	
Surgical treatment for morbid obesity.		✓ Covered when medically necessary or when covered under Original Medicare.
Travel immunizations.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Travel oxygen, including but not limited to: portable concentrators, three-liter concentrators, gaseous portable systems, smaller tank sizes, conserving devices and oxygen services furnished by an airline when the oxygen is purchased in addition to a standard month's supply.	✓	

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 emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, 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.

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 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 *one year*** of the date you received the service or item.

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

MediGold
ATTN: Member Services
3100 Easton Square Place
Third Floor – Health Plan
Columbus, Ohio 43219

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 rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or 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 the 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 Member Services.

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 Daniel Hayes, 1-888-898-6129 (TTY 711). 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 primary care provider in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 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 at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

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

NOTICE OF PRIVACY PRACTICES (Effective Date: April 14, 2003; Revised: August 24, 2020)

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

PROTECTION OF INFORMATION

MediGold[1] understands that your information is highly personal and is committed to safeguarding your protected health information ("PHI"). Please read this Notice of Privacy Practices thoroughly. MediGold is required by law to maintain the privacy of PHI. We are required to provide you with notice of our legal duties and privacy practices with respect to PHI. We will only use or disclose your PHI as permitted or required by applicable state or federal law. MediGold can help you understand our privacy practices and your rights.

PERMITTED USES AND DISCLOSURES

Treatment:
We may use and disclose PHI to doctors, hospitals, pharmacies and/or other health care providers who are involved in your care and treatment.

For example, doctors may request PHI from us for coordination of care purposes or doctors may send MediGold information about your diagnosis and treatment plan so we can arrange additional services. MediGold may also disclose your PHI to health care providers in connection with preventive health, early detection and disease and case management programs.

Payment:
To help pay for your covered services, we may use and disclose PHI in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility and coverage; determining prescription drug compliance; collecting premiums; calculating cost sharing amounts and coordination of benefits; and responding to complaints, appeals and requests for external review.

For example, we may use your medical history and other health information about you to decide whether a treatment is a covered benefit and what the payment should be – and during the process we may disclose information to your provider. We also use PHI to obtain payment for any mail-order pharmacy services provided to you or to obtain payment for premiums.

Health Care Operations:
MediGold may use and disclose PHI about you to develop better services for you. Other routine operations requiring use and disclosure of PHI include population health and wellness; underwriting and premium rating; administration of pharmacy benefit programs; coordination of benefits; and other general administrative activities including information resources and data management. MediGold is specifically prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes as required by the Genetic Information and Nondiscrimination Act ("GINA").

Other Uses and Disclosures:

Information and Health Promotion Activities: MediGold may use and disclose some of your PHI for certain health promotion activities. For example, your name and address may be used to send you newsletters or general communications. MediGold may also send you information based on your own health concerns. MediGold may send you this information if it has determined that a product or service may help you. These communications will explain how the products or services relate to your well-being and can improve your health.

Research: Under certain circumstances, MediGold may use and disclose your PHI for research purposes. Research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Researchers are required to safeguard all PHI they receive. MediGold may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must first be cleared through this special approval process.

More Stringent State and Federal Laws: There may be times where certain areas of state law is more stringent than the Health Insurance Portability and Accountability Act and associated regulations ("HIPAA"). Certain federal laws also are more stringent than HIPAA. MediGold will continue to abide by these more stringent state and federal laws.

- **More Stringent Federal Laws:** The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.
- **More Stringent State Laws:** State law is more stringent when the individual is entitled to greater access to records than under HIPAA. State law also is more restrictive when the records are more protected from disclosure by state law than under HIPAA.

PERMITTED USES OR DISCLOSURES WITH AN OPPORTUNITY FOR YOU TO AGREE OR OBJECT

Family/Friends: MediGold may disclose PHI about you to a friend or family member who is involved in your medical care. MediGold may also give information to someone who helps you pay for your care. You have a right to request that your PHI not be shared with some or all of your family or friends.

OTHER PERMITTED USES AND DISCLOSURES

MediGold may also disclose your PHI as follows:

Administer your plan: We may disclose PHI to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Business Associates: To organizations that provide services to us and assure us in writing that they will protect the information. MediGold will give out as little information as possible to

allow our business associates to complete these tasks and MediGold requires these business associates to appropriately safeguard the privacy of your information.

Membership in Trinity Health: Members of Trinity Health (including MediGold) participate together in an organized health care arrangement for utilization review and quality assessment activities with respect to this information. Members of Trinity Health may also use your PHI for treatment, payment and/or health care operations permitted by HIPAA with respect to operations of the organized health care arrangement.

USES AND DISCLOSURES PERMITTED BY PUBLIC POLICY OR LAW WITHOUT YOUR AUTHORIZATION

Law Enforcement: MediGold will use and disclose PHI to federal, state, and local law enforcement officials as required by applicable law, such as identifying a criminal suspect or a missing person, or providing information about a crime victim or criminal conduct.

Legal Proceedings: MediGold will use and disclose PHI in response to a court order or other lawful purpose.

Required by Law: MediGold will disclose PHI about you when required by federal, state or local law to make reports or other disclosures. MediGold may also make disclosures for judicial and administrative proceedings such as lawsuits or other disputes in response to a court order. MediGold will disclose your medical information to government agencies concerning victims of abuse, neglect or domestic violence. MediGold will report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies. Specialized government functions will include military and veteran's activities, national security and intelligence activities, and protective services for the President and others. MediGold will make certain disclosures that are required in order to comply with workers' compensation or similar programs.

Public Health Oversight or Safety: MediGold will use and disclose PHI to avert a serious threat to health and safety of a person or the public. MediGold will use and disclose PHI to Public Health Agencies for immunizations, communicable diseases, etc. MediGold will use and disclose PHI for activities related to the quality, safety or effectiveness of FDA-regulated products or activities, including collecting and reporting adverse events, tracking and facilitating product recalls, etc. and post-marketing surveillance.

Health Information Exchange (HIE): Your PHI may be disclosed to an approved health information exchange ("HIE") to facilitate the provision of health care to you. The HIE has a duty under the law to maintain appropriate administrative, physical and technical safeguards to protect the privacy and security of PHI. Only authorized individuals may access and use PHI from the HIE. You or your personal representative have the right to request in writing that MediGold do either or both of the following: (i) not disclose any of the your PHI to the HIE; and (ii) not disclose specific categories of your PHI to the HIE. Any restrictions on the disclosure of PHI you request as described in the prior sentence may result in a health care provider not having access to information that is necessary for the provider to render appropriate care to you. MediGold will honor all requests for restrictions on disclosure of PHI to health information

exchange(s) as required by law. For more information or to request restrictions, please contact Member Services by mail to 3100 Easton Square Place, Third Floor – Health Plan, Columbus, Ohio 43219, or by calling Member Services at 1-800-240-3851 (TTY 711), 8 a.m. - 8 p.m., 7 days a week.

USE OR DISCLOSURE REQUIRING YOUR AUTHORIZATION

Marketing: MediGold is not permitted to provide your PHI to any other person or company for marketing to you of any products or services other than certain MediGold's products or services unless you have signed an authorization. If MediGold receives direct or indirect payment from or on behalf of a third party to make a communication that encourages you to purchase or use that third party's product or service we will obtain your authorization.

Psychotherapy Notes, Sale of PHI, and Other Uses: In addition to marketing and research, the following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes (if recorded by a mental health professional); and (ii) disclosures that constitute a sale of PHI. MediGold does not share or sell your PHI to companies that market health care products or services directly to consumers for use by those companies to contact you, such as drug companies, unless you have signed an authorization.

Other uses and disclosures of your medical information not described in this Notice will be made only with your written authorization. Written authorizations will let you know why we are using your PHI. You have the right to revoke an authorization at any time. If you have questions regarding authorizations, please call Member Services.

INDIVIDUAL RIGHTS

Under the federal privacy regulations, you have the following rights regarding your personal health information. You can exercise these rights as described below by contacting MediGold, either by mail to 3100 Easton Square Place, Third Floor – Health Plan, Columbus, Ohio 43219, or by calling Member Services at 1-800-240-3851 (TTY 711), 8 a.m. - 8 p.m., 7 days a week.

Right to Confidential Communications: You have the right to request in writing to receive confidential communications of your PHI by alternative means or at alternative locations. For example, you may request that MediGold only contact you at work or by mail.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your PHI. MediGold will consider your request, but is not required to agree to your requested restrictions.

Right to Inspect and Copy: With some exceptions you have the right to inspect and copy information about your PHI as long as we maintain the information. In certain limited circumstances, MediGold may be required to deny your request.

Right to Amend: With some exceptions you have the right to request in writing an amendment of your PHI for as long as MediGold maintains the information.

Right to an Accounting: With some exceptions you have a right to receive an accounting of certain disclosures of your PHI that MediGold has made.

Right to Receive a Copy of this Notice: You have the right to receive a paper copy of this Notice of Privacy Practices upon request.

Right to Notification of Breach. You will receive notification of any breach of your unsecured PHI.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with MediGold. You may submit complaints directly to MediGold, either by mail to 3100 Easton Square Place, Third Floor – Health Plan, Columbus, Ohio 43219, or by calling Member Services at 1-800-240-3851 (TTY 711), 8 a.m. - 8 p.m., 7 days a week. ***MediGold assures you that filing a complaint will in no way affect your covered services or membership in our plan – we will not retaliate against you for filing a complaint.*** Complaints may also be filed with the Department of Health and Human Services. Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

FURTHER INFORMATION

To obtain additional information, please contact Member Services at toll-free at 1-800- 240-3851 (TTY 711). Member Services is available 8 a.m. - 8 p.m., 7 days a week.

CHANGES TO THIS NOTICE

MediGold will abide by the terms of the notice currently in effect. MediGold reserves the right to change the terms of its notice and to make the new notice provisions effective for all PHI that it maintains. We will notify you in writing of any substantial changes to the notice. Our current Notice of Privacy Practices is available on our website at MediGold.com[2].

[1] For purposes of this notice, "MediGold" and the pronouns "we", "us" and "our" refer to Mount Carmel Health Plan, Inc. and Mount Carmel Health Insurance Company and all their respective subsidiaries, including but not limited to the entities listed on the last page of this notice. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

[2] Coverage may be underwritten or administered by one or more of the following companies: Mount Carmel Health Plan, Inc.; Mount Carmel Health Insurance Company; and Mount Carmel Health Plan of Idaho, Inc.

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

As a member of MediGold Mount Carmel Cash Back No Premium MA Only (HMO), you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about 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 in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

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

- **Get the form.** 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 Ohio Department of Health. Call 1-800-342-0553.

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

Section 1.8 How to get more information about your rights

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

- You can **call Member Services**.
- You can **call the 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 Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage document to learn what 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:
  - You must continue to pay your premium for your Medicare Part B to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
  - **If you move *outside* of our plan service area, you 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 Chapter 2, Section 3 of this document.

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

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

- You **can call us at Customer Service**.
- You **can get free help** from your SHIP.
- **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 Service 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 MediGold.com/For-Members/Resources/Forms.)

- 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 Service 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 MediGold.com/For-Members/Resources/Forms.) 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 to only 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 Service. You can also get help or information from government organizations such as your SHIP.

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

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

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

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 *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **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 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. 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. (See Section 9 of this chapter for information on complaints.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent 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 it,s 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" or "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 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 services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

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

- We must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.)

- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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

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

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

- 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 Service 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 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 Service 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 Service. Or call your SHIP, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
-
  - If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service 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 may apply.

If the review organization says no:

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

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?

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first

appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

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

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

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

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

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

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

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 Service. Or call your SHIP, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

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

Your deadline for contacting this organization.

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

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.

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

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

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal (within a day or two, at the most). 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

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 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,** 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 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, an **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 service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.

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

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice 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 Member Services? • 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 Member Services or other staff at the plan? o 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?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • 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 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 Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Your grievance letter must be sent to us within 60 days of the event or situation that prompted your complaint.** You may be permitted additional time to file a grievance if there were extenuating circumstances found by the plan to be reasonable cause for your delay, which must also be explained in detail within your letter.

  For a grievance issue related to medical care, mail to:

  MediGold
  ATTN: Appeals and Grievances Department
  3100 Easton Square Place
  Third Floor – Health Plan
  Columbus, Ohio 43219

- **Upon receipt of your grievance letter**, MediGold will thoroughly review, research and respond to your letter in a timely manner and provide written response to your grievance within 30 days of our receipt of your letter. You may also request to have MediGold respond to your grievance within 24 hours (also known as a fast complaint or expedited grievance) in the following situations:

  - If you have a complaint about MediGold extending the timeframe needed to make an organization determination or a decision regarding a reconsideration request.
  - If you have a complaint about MediGold refusing to grant a request for an expedited organization determination or reconsideration request. In some instances,

MediGold may need additional time to give full consideration to your original grievance. In such cases, we will ask for a 14-day extension. You will be notified in writing if additional time is needed and you will be given specific information on how your grievance is being handled.

- 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 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 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

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

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

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.

- **During the annual Medicare Advantage Open Enrollment Period**, you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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.

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.

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

Section 2.4 Where can you get more information about when you can end your membership?

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

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

SECTION 3 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll**. Contact Member Services if you need more information on how to do this (phone numbers are printed in the back of this booklet). • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from MediGold Mount Carmel Cash Back No Premium MA Only (HMO) 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 services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO) must end your membership in the plan in certain situations

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

MediGold Mount Carmel Cash Back No Premium MA Only **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 Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for *90 days*.

- We must notify you in writing that you have *90 days* to pay the plan premium before we end your membership.

Where can you get more information?

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

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

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 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.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

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

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

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

If you need these services, contact Member Services.

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

Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor – Health Plan, Columbus, Ohio 43219, 1-888-898-6129 (TTY 711), 1- 833-802-2495 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Daniel Hayes, Member Services Manager, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/office/file/index.html*.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-240-3851 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-240-3851 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-240-3851 (TTY 711). 我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-240-3851 (TTY 711). 我們講中文的人員將樂意 為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-240-3851 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-240-3851 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1- 800-240-3851 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-240- 3851 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-240-3851 (TTY 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвонитенам по телефону 1-800-240-3851 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-240-3851 (TTY 711). <1. سيقوم شخص ما بتحدث بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे ◌ा◌ या दवा की योजना के बारे म◌ आपके ◌िकसी भी प्र◌ के जवाब देने के ◌िलए हमारे पास मु◌ दुभा◌िषया सेवाएँ उपल◌ ह◌. एक दुभा◌िषया प्रा◌ करने के ◌िलए, बस हम◌ 1-800-240-3851 (TTY 711) पर फोन कर◌. कोई ◌◌◌ जो ◌ह◌ी बोलता है आपकी मदद कर सकता है. यह एक मु◌ सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-240-3851 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-240-3851 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-240-3851 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1- 800-240-3851 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の 健康 健康保険と薬品 処方薬プラ ンに 関す るご 質問に お 答えす るた めに 、無料の 通訳サ ービ スがあ りますございます。通訳をご 用命に なるに は、1-800-240- 3851 (TTY 711) にお電話く ださい。日 本語を話す 人 者 が支援いたします。これ は無料のサ ービ スです。

Armenian: Մենք ունենք բանավոր թարգմանչի անվճար ծառայություններ, որոնց օգնությամբ կստանաք մեր բժշկական ապահովագրության կամ դեղերի ծրագրի վերաբերյալ բոլոր հնարավոր հարցերի պատասխանները: Թարգմանչի ծառայություններ պատվիրելու համար պարզապես զանգահարեք 1-800-240-3851 (TTY
711): Անձնակազմի որևէ անդամ, որը խոսում է անգլերեն կամ այլ լեզվով, կարող է օգնել ձեզ: Ծառայությունն անվճար է:

Cambodian: ។ នជ។ល់ជូនេស។បក្រៃបេ។យតតគិតៃថ។ េដើម្បីេឆ។ើយេ។នឹងសណ្ឋ រ។មួយ ែដលអ។ក។ច។នអំពីគ្រ។ងសុខ។ព ឬឱសថរបស់េយើង។ េដើម្បីទទួល។នអ។កបក្រៃប សូ មទូរសព។មកេយើងខ។ ។ំ។មរយៈេលខ 1-800-240-3851 (TTY 711)។ េ។ះនឹងអ។កែដល។ចនិ។យ។ែ។ខ។រនឹងជួយអ។ក។ េនះគឺ។ស។តតគិតៃថ។ ។

Farsi:

ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد طرح سلامت یا در مورد داروی خود داشته باشید پاسخ دهیم. برای دریافت مترجم، کافیست با ما تماس بگیرید 1-800-240-3851 (TTY 711). فردی که به زبان انگلیسی/زبان شما صحبت می‌کند می‌تواند به شما کمک کند. این خدمت، رایگان است.

Hawaiian: Loaʻa ke kōkua unuhi ʻōlelo no ka pane ʻana i kāu mau nīnau no kā mākou papa hana olakino a lāʻau lapaʻau paha. Ke makemake ʻoe e kauoha no kēia kōkua, e kelepona mai iā mākou ma ka helu 1-800-240-3851 (TTY 711). Na kekahi kanaka ʻōlelo Hawaiʻi e kōkua iā ʻoe. He kōkua uku ʻole.

Ilocano: Adda libre a serbisiomi a panagipatarus tapno masungbatan ti aniaman a saludsodmo panggep iti planomi iti salun-at wenno agas. Tapno makaala iti agipatarus, tawagandakami laeng iti 1-800-240-3851 (TTY 711). Matulungannaka ti Ilocano ti pagsasaona. Libre daytoy a serbisyo.

Ilocano: Adda libre a serbisiomi a panagipatarus tapno masungbatan ti aniaman a saludsodmo panggep iti planomi iti salun-at wenno agas. Tapno makaala iti agipatarus, tawagandakami laeng iti 1-800-240-3851 (TTY 711). Matulungannaka ti Ilocano ti pagsasaona. Libre daytoy a serbisyo.

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, MediGold Mount Carmel Cash Back No Premium MA Only (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 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 MediGold Mount Carmel Cash Back No Premium MA Only (HMO), you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

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

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

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs.

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

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

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

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

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

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

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

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

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 does not involve coverage or payment disputes.

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

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

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

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

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

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**. MediGold Mount Carmel Cash Back No Premium MA Only (HMO) does not offer Medicare prescription drug coverage.

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).

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

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

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

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

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. 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.

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 network (preferred) and out-of-network (non-preferred) providers.

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

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

Prior Authorization – Approval in advance to get services. 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.

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.

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3100 Easton Square Place
Third Floor – Health Plan
Columbus, Ohio 43219
MediGold.com

MediGold Mount Carmel Cash Back No Premium MA Only (HMO) Member Services	
Method	**Member Services – Contact Information**
CALL	**1-800-240-3851** Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. We are here to serve you from 8 a.m. – 8 p.m., 7 days a week.
WRITE	**MediGold** Attn: Member Services 3100 Easton Square Place Third Floor – Health Plan Columbus, Ohio 43219
WEBSITE	**MediGold.com**

Ohio Senior Health Insurance Information Program (OSHIIP)	
OSHIIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.	
Method	**Ohio Senior Health Insurance Information Program (OSHIIP) - Contact Information**
CALL	**1-800-686-1578**
WRITE	**Ohio Department of Insurance** 50 West Town Street Third Floor – Suite 300 Columbus, Ohio 43215
WEBSITE	**insurance.ohio.gov/about-us/divisions/oshiip**

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