2023 Evidence of Coverage MediGold Mount Carmel No Premium Choice (PPO)

(serving Central and Southwest Ohio)

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

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of MediGold Mount Carmel No Premium Choice (PPO)

This document gives you the details about your Medicare health care and prescription drug 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 No Premium Choice (PPO), is offered by Mount Carmel Health Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Mount Carmel Health Insurance Company. When it says "plan" or "our plan," it means MediGold Mount Carmel No Premium Choice (PPO).)

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 formulary, pharmacy network, and/or 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 and prescription drug 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 No Premium Choice (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, MediGold Mount Carmel No Premium Choice (PPO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

MediGold Mount Carmel No Premium Choice (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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 and prescription drugs. 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 and the prescription drugs available to you as a member of MediGold Mount Carmel No Premium Choice (PPO).

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

If you are confused, concerned, or just have a question, please contact 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 No Premium Choice (PPO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, 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 No Premium Choice (PPO) covers 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 No Premium Choice (PPO) 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 No Premium Choice (PPO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- 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 No Premium Choice (PPO)

MediGold Mount Carmel No Premium Choice (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Ohio: Adams, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Coshocton, Darke, Delaware, Fairfield, Fayette, Franklin, Greene, Guernsey, Hamilton, Harrison, Highland, Hocking, Holmes, Jackson, Knox, Licking, Logan, Madison, Miami, Monroe, Montgomery, Morgan, Noble, Perry, Pickaway, Pike, Preble, Ross, Shelby, Union, Vinton, Warren and Washington.

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 No Premium Choice (PPO) if you are not eligible to remain a member on this basis. MediGold Mount Carmel No Premium Choice (PPO) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. 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 No Premium Choice (PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* lists our network providers and pharmacies. **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 any plan cost sharing as payment in full.

The *Provider/Pharmacy Directory* lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the Pharmacy Directory to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

You must use network providers to get your medical care and services. Also, with few exceptions, you must get your prescriptions filled at a network pharmacy if you want our plan to cover (help you pay for) them. 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 No Premium Choice (PPO) authorizes use of out-of-network providers.

You can use the *Provider/Pharmacy Directory* to find the network provider and pharmacy you want to use. **We strongly suggest that you review our current *Provider/Pharmacy Directory* to see if your providers and pharmacies are still in our network.**

If you don't have your copy of the *Provider/Pharmacy Directory*, you can request a copy from Member Services. You can also see the *Provider/Pharmacy Directory* at MediGold.com/Find-A-Provider or request one from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers and pharmacies.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in MediGold Mount Carmel No Premium Choice (PPO). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the MediGold Mount Carmel No Premium Choice (PPO) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website MediGold.com/Formulary or call Member Services.

SECTION 4 Your monthly costs for MediGold Mount Carmel No Premium Choice (PPO)

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)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for MediGold Mount Carmel No Premium Choice (PPO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 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 $43 per month. You pay this monthly premium in addition to your Medicare Part B premium and MediGold plan 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 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late

enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in MediGold Mount Carmel No Premium Choice (PPO), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.

- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

If you pay a Part D late enrollment penalty, there are three ways you can pay the penalty.

Option 1: Paying by check

Your monthly premium is due by the tenth (10th) day of each month. Members will receive monthly billing statements once they enroll. If you intend to pay MediGold by check or money order each month, just detach the bottom portion of your monthly billing statement and send it along with your payment, using the return envelope included with your billing statement. Be sure to follow the instructions on your billing statement and complete all required information on the bottom portion of the billing statement. Remember to include your first and last name on your check or money order, as well as your MediGold Identification Number (Member ID).

Your check or money order should be made payable to MediGold (not to Centers for Medicare & Medicaid Services or U.S. Department of Health and Human Services).

All payments should be sent to:

MediGold
P.O. Box 394789
Cleveland, Ohio 44101-4789

Please remember:

- Be sure to detach the bottom portion of your billing statement and include it with your check or money order.
- If you're paying an amount other than the amount listed on your billing statement, please note that amount on the portion of the billing statement you mail along with your check or money order.
- Be sure your check or money order is paid to the order of MediGold.
- Remember to sign your check or money order (if applicable).
- Do not post-date your check or use a third-party check.
- Be sure to include your MediGold Member ID in the memo portion of your check or money order.
- Use a separate envelope and separate check or money order for each member's premium payment.
- When paying by mail, it is important to use the envelope that MediGold provides and to be sure to place a stamp on the envelope before mailing.
- Your payment must be received by the 10th of each month.
- Your cancelled check serves as a receipt for mailed payments.
- The address listed above is only for premium payments. All other communication should be mailed to the address listed in Chapter 2, Section 1 of this booklet.

Option 2: You can pay by Electronic Funds Transfer (EFT)

Instead of paying by check or money order, you may have your payment deducted automatically from your bank account. We call this the Electronic Funds Transfer (EFT) Payment Option. This

option saves you time and the cost of postage. The EFT option automatically deducts your payment from your bank account around the 10th day of each month.

- You must obtain, complete and submit an EFT Payment Option Form to MediGold (which is available online at MediGold.com).
- You must attach to the form a voided (or cancelled) check or a savings deposit slip that includes your bank account number (either checking or savings) and bank routing number on it. This must be for the account listed on the form. If your bank does not have a slip for your individual account, provide a letter from the bank indicating both your bank account number and bank routing number.
- You must send your completed form and voided check or savings deposit slip to MediGold at the address below. Do not send these materials to the billing office address listed on your billing statement.

MediGold
Attn: Premium Billing Department
3100 Easton Square Place
Third Floor – Health Plan
Columbus, Ohio 43219

- Unless otherwise noted, your first EFT payment will occur on or around the 10th day of the month following MediGold's receipt of the completed EFT Payment Option Form.
- Please note: Any and all past due premiums will also be withdrawn from your account in your first withdrawal.
- We will send a copy of a monthly billing statement to you only upon your request.
- If we are unsuccessful withdrawing your payment due to non-sufficient funds, we will either make an attempt to withdraw all funds due at the next month's withdrawal or terminate your EFT payment option and update the amount on your billing statement. If the EFT withdrawal is rejected again, you may be required to pay directly by check.
- If you should ever want to change the bank account that we are using to automatically draw your payment, you will need to complete and submit a new automatic payment request. Please notify us in writing or by calling Member Services.

Option 3: Having your Part D late enrollment penalty taken out of your monthly Social Security check

What to do if you are having trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the 10th day of the previous month. If you are required to pay a Part D late enrollment penalty, that penalty is due in our office by the the 10th day of the previous month. If we have not received your penalty payment by the 10th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your Part D late enrollment penalty payment, if owed, within 90 days. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your Part D late enrollment penalty, if owed, on time, please contact Member Services to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your Part D late enrollment penalty, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for the penalty you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at 1-800-240-3851 between 8 a.m. – 8 p.m., 7 days a week. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 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.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you ever lose your low income subsidy ("Extra Help"), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 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, pharmacists, 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 and drugs 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 7 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 No Premium Choice (PPO) 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 No Premium Choice (PPO) 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 or Part D prescription drugs. 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 or Part D prescription drugs, see Chapter 9 (*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

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	1-866-785-5714, option 2 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week
FAX	1-855-633-7673

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
WRITE	CVS Caremark Part D Exceptions Department P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
WEBSITE	MediGold.com

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	1-866-785-5714, option 2 Calls to this number are free. 24 hours a day, 7 days a week. *Fast Appeals* (an expedited process) 1-866-785-5714, option 2
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week
FAX	1-855-633-7673
WRITE	CVS Caremark Part D Appeals Department P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
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 or pharmacies, 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 9 (*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 No Premium Choice (PPO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Method	Complaints about Part D Prescription drugs – Contact Information
CALL	1-866-785-5714, option 2 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week
WRITE	CVS Caremark Medicare Part D Grievance Department P.O. Box 30016 Pittsburgh, PA 15222-0330

Method	Complaints about Part D Prescription drugs – Contact Information
MEDICARE WEBSITE	You can submit a complaint about MediGold Mount Carmel No Premium Choice (PPO) 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 or a drug 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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Medical 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

Method	Part D Payment Requests – Contact Information
CALL	1-866-785-5714, option 2 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	Medicare Part D Paper Claims P.O. Box 52066 Phoenix, AZ 85072-2066
WEBSITE	www.caremark.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 No Premium Choice (PPO). • **Tell Medicare about your complaint:** You can submit a complaint about MediGold Mount Carmel No Premium Choice (PPO) 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 LLC.

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 - Ohio's Quality Improvement Organization – Contact Information
CALL	1-888-524-9900 Helpline representatives are available 9 a.m. 5 p.m., Monday through Friday, and 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.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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 Ohio Department of Medicaid.

Method	Ohio Department of Medicaid – Contact Information
CALL	1-800-324-8680 Available 7:00 am to 8:00 pm, Monday through Friday, 8:00 a.m. to 5 p.m. on Saturdays
WRITE	Ohio Department of Medicaid 50 West Town Street, Suite 400 Columbus, Ohio 43215
WEBSITE	www.medicaid.ohio.gov

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- If you think you may qualify for Low Income Subsidy (LIS), please contact MediGold's partner, Premium Assist℠, at 1-877-236-4471 (TTY 711), Monday through Friday between 9 a.m. and 7:30 p.m. If you have already been awarded LIS but are not receiving the proper discounts when filling your prescriptions, please contact Member Services so that we may collect the information needed to update your records.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost sharing assistance. The Ohio Department of Health (ODH) administers the Ohio HIV Drug Assistance Program (OHDAP).

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call The Ohio Department of Health, Ohio HIV Drug Assistance Program (OHDAP).

Method	Ohio HIV Drug Assistance Program – Contact Information
CALL	1-800-777-4775
WRITE	Ohio HIV Drug Assistance Program (OHDAP) HIV Care Services Section Ohio Department of Health 246 N. High Street Columbus, Ohio 43215
WEBSITE	www.odh.ohio.gov

SECTION 8 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 9 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. If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our 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 equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, MediGold Mount Carmel No Premium Choice (PPO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

MediGold Mount Carmel No Premium Choice (PPO) will generally cover your medical care as long as:

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

network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

The providers in our network are listed in the *Provider/Pharmacy Directory*.

If you use an out-of-network provider, your share of the costs for your covered services may be higher.

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

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

Section 2.1 You 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 either in- or out-of-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/Pharmacy 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 in our plan or you will pay more for covered services.

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 in- or out-of-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?

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 that are 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 Chapter 9, Section 5 for further information about requesting coverage from an out-of-network provider.
- If you find out that 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 9.

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

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

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

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost sharing amount. See Section 3 for more information about these situations.

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.

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

What if it wasn't a medical emergency?

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

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

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

What are "urgently needed services"?

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

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.html 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. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) 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 No Premium Choice (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. 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 7 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 No Premium Choice (PPO), however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call 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 to our plan before owning the item.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage MediGold Mount Carmel No Premium Choice 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 No Premium Choice 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 No Premium Choice (PPO). Later in this chapter, you can find information about medical services that are not covered.

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

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

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

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

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

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

- Your **in-network maximum out-of-pocket amount** is $5,700. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. The amounts you pay for plan premiums, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with a double asterisk (**) in the Medical Benefits Chart. If you have paid $5,700 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $8,950. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with a double asterisk (**) in the Medical Benefits Chart. If you have paid $8,950 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay 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 No Premium Choice (PPO), 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. You will generally have higher copays when you obtain care from out-of-network providers.
- 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 obtain 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 obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- 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 No Premium Choice (PPO) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from MediGold Mount Carmel No Premium Choice (PPO).
    - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:

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 Admission (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

  - You never need approval in advance for out-of-network services from out-of-network providers.

- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

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

  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 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	**In- and Out-of-Network** 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.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	**In-Network** $20 copay **Out-of-Network** $60 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: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. 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.	**In- and Out-of-Network** $275 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). $325 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 calendar year. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In- and Out-of-Network** 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.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women aged 40 and older. • Clinical breast exams once every 24 months.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network** $40 copay per visit. **Out-of-Network** 40% coinsurance per visit.

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy 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).	**In- and Out-of-Network** 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	**In- and Out-of-Network** 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.	**In-Network** $20 copay per visit. **Out-of-Network** $60 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).	**In- and Out-of-Network** 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

Services that are covered for you	**What you must pay** when you get these services
• Fecal immunochemical test (FIT). DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	for a screening exam of the colon when it includes a biopsy or removal of any growth during the procedure. Refer also to the 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:** PPO members who have the preventive and comprehensive dental, as well as those who purchase the additional Optional Supplemental Dental benefit, may receive dental care from a MediGold Dental network provider or an out-of-network provider. Services received from providers who do NOT participate in the MediGold	**In-Network** $40 copay for non-routine dental services. **Out-of-Network** 40% coinsurance for non-routine dental services. **In- and Out-of-Network** **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.**

Services that are covered for you	**What you must pay** when you get these services
Dental network may result in higher out-of-pocket costs. Dental benefits are administered by Dental Benefit Providers.	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, 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.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you 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 2 diabetes screenings every 12 months.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. An office or facility copay may apply if other services are provided during your visit. **In-Network**

Services that are covered for you	**What you must pay** when you get these services
custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or 1 pair of depth shoes and 3 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/Pharmacy Directory* for a complete list of diabetic supply providers in the plan's network. 20% coinsurance for therapeutic shoes and inserts. **Out-of-Network** 30% coinsurance for diabetes self-monitoring equipment and supplies, and for therapeutic shoes and inserts.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) 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.	**In-Network** 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 No Premium Choice (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MediGold Mount Carmel No Premium Choice (PPO) is 20% coinsurance. **Out-of-Network** 30% coinsurance. Your cost sharing for Medicare oxygen equipment coverage is 30% coinsurance. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in MediGold Mount Carmel No Premium Choice (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MediGold Mount Carmel No Premium Choice (PPO) is 30% coinsurance.
Emergency care Emergency care refers to services that are:	**In- and Out-of-Network** $90 copay per visit. If you are admitted to the hospital within 48 hours for the

Services that are covered for you	**What you must pay** when you get these services
• 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.	same condition, you pay $0 for the emergency room visit. 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 7 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 (TTY 711), from 8 a.m. – 8 p.m. ET, Monday through Friday.	**In- and Out-of-Network** $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.
Hearing aid benefit** Hearing aid benefit**	**In- and Out-of-Network**

Services that are covered for you	**What you must pay** when you get these services
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 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.

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • One routine hearing exam.** • One Medicare-covered exam to diagnose and treat hearing and balance issues each calendar year.	**In-Network** $0 copay for routine hearing exam (up to one per calendar year)** $40 copay for diagnostic exam to treat hearing and/or balance issues each calendar year. **Out-of-Network** $60 copay for routine hearing exam (up to one per calendar year)** $60 copay for diagnostic exam to treat hearing and/or balance issues each calendar 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.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months. For women who are pregnant, we cover: • Up to three screening exams during a pregnancy.	**In- and Out-of-Network** 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:	**In-Network** $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
• 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.	**Out-of-Network** 50% coinsurance for home health services. 30% coinsurance when Part B medical equipment and supplies are billed separately.
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	**In-Network** 20% coinsurance for home infusion drug component 20% coinsurance for home infusion therapy supplies **Out-of-Network** 30% coinsurance for home infusion drug component 30% coinsurance for home infusion therapy supplies **In- and Out-of-Network** 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:	**In- and Out-of-Network** 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 No Premium Choice (PPO). Hospice consultations are included as part of inpatient hospital care. Physician service

Services that are covered for you	**What you must pay** when you get these services
• 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. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services. For services that are covered by MediGold Mount Carmel No Premium Choice (PPO) but are not covered by Medicare Part A or B: MediGold Mount Carmel No Premium Choice (PPO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original	cost-sharing may apply for outpatient consultations.

Services that are covered for you	**What you must pay** when you get these services
Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice)*. **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. • 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. We also cover some vaccines under our Part D prescription drug benefit such as Zostavax for shingles. See Chapter 6, Section 8.1 for more information	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
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).	**In- Network** $375 copay per day for days 1-5 $0 copay per day after day 5 **Out-of-Network** 40% coinsurance per hospital admission. 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
• 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 MediGold Mount Carmel No Premium Choice (PPO)provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage 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 3 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?	

Services that are covered for you	**What you must pay** when you get these services
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. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	**In- Network** $370 copay per day for days 1-5 $0 copay per day after day 5 **Out-of-Network** 40% coinsurance per inpatient mental health admission. If you get authorized inpatient care from an out-of-network hospital after your emergency condition is stabilized, your cost is the cost you would pay at a network hospital.
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	**In- and Out-of-Network** 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.

Services that are covered for you	**What you must pay** when you get these services
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.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In- and Out-of-Network** 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:	**In-Network** 20% coinsurance.

Services that are covered for you	**What you must pay** when you get these services
• 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 and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. *Prior authorization rules may apply for select services. Refer to Chapter 4, Section 2.1 for more information.	**Out-of-Network** 30% coinsurance.
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.	**In-Network** $20 copay per visit.** **Out-of-Network** $60 copay per visit.** **In- and Out-of-Network** This service has a limit of 6 visits per year.

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.	**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.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling. • Individual and group therapy. • Toxicology testing. • Intake activities • Periodic assessments	**In-Network** $40 copay. **Out-of-Network** $60 copay.
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.	**In-Network** $50 copay for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder or foot) $0 to $60 copay for diagnostic tests (examples include but are not limited to electrocardiogram [ECG/EKG], duplex scan of the heart and esophageal function

Services that are covered for you	**What you must pay** when you get these services
• 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 3 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.	test) in a physician's office. There is no copay for COVID-19 testing and specified testing-related services. $210 copay for diagnostic radiological PET scan. $210 copay for all other diagnostic radiological services other than PET scan. 20% coinsurance for therapeutic radiological services. 20% coinsurance for Part B drugs and contrast materials used in conjunction with outpatient diagnostic services. $10 copay for lab tests. $0 copay for covered blood, blood storage, processing and handling services. **Out-of-Network** 40% coinsurance for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder or foot. 40% coinsurance for diagnostic tests (examples include but are not limited to an electrocardiogram [ECG/EKG], duplex scan of the heart and esophageal function test). 40% coinsurance for diagnostic radiological services (advanced imaging examples include but are not limited to MRI, CT scan and PET scan. 40% coinsurance for therapeutic radiological services.

Services that are covered for you	**What you must pay** when you get these services
	30% coinsurance for Part B drugs and contrast materials used in conjunction with outpatient diagnostic services. $20 copay for lab tests. 40% coinsurance for covered blood, blood storage, processing and handling services **In- and Out-of-Network** Refer also to the Outpatient Hospital and 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 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	**In-Network** $0 per visit. **Out-of-Network** 40% coinsurance per visit.

Services that are covered for you	**What you must pay** when you get these services
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.	
Outpatient hospital services* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **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-	**In-Network** $300 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility. $10 copay for lab tests $50 copay for X-ray services. $210 copay for diagnostic radiological PET scan services. $210 copay for all other diagnostic radiological services other than PET scan services. 20% coinsurance for therapeutic radiological services. 20% coinsurance for Part B drugs and biologicals when provided during an outpatient hospital service. $10 copay per visit to a Coumadin clinic. $40 copay per visit to a respiratory therapy department. **Out-of-Network** 40% coinsurance per visit for surgery performed in an ambulatory surgical center

Services that are covered for you	**What you must pay** when you get these services
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.	(ASC) or in an outpatient hospital facility. $20 copay for lab tests. 40% coinsurance for X-ray services. 40% coinsurance for diagnostic radiological services (advanced imaging examples include but are not limited to MRI, CT scan and PET scan. 40% coinsurance for therapeutic radiological services. 30% coinsurance for Part B drugs and biologicals when provided during an outpatient hospital service. 40% coinsurance per visit to a Coumadin clinic. 40% coinsurance per visit to a respiratory therapy department. **In- and Out-of-Network** 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. Some self-administered drugs may be reimbursable under your Part D benefit. Coinsurance and copays are separate member responsibilities. If you receive multiple services from the same provider on the same date, you

Services that are covered for you	**What you must pay** when you get these services
	will be responsible for the highest copay for services in addition to coinsurance, if applicable.
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.	**In-Network** $40 copay per individual visit. $40 copay per group visit. **Out-of-Network** $60 copay per individual visit. $60 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).	**In-Network** $40 copay per visit. **Out-of-Network** $60 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.	**In-Network** $40 copay per individual visit. $40 copay per group visit. **Out-of-Network** 40% coinsurance per individual visit. 40% coinsurance 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	**In-Network** $300 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility.

Services that are covered for you	**What you must pay** when you get these services
an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	20% coinsurance may apply for Part B drugs, durable medical equipment, prosthetic devices and supplies when provided during a surgical visit. **Out-of-Network** 40% coinsurance per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility. 30% coinsurance may apply for Part B drugs, durable medical equipment, prosthetic devices and supplies when provided during a surgical visit. **In- and Out-of-Network** For some non-invasive surgical procedures and tests (examples include but are 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 also 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

Services that are covered for you	**What you must pay** when you get these services
	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. • 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.	**In- and Out-of-Network** Up to $105 allowance every quarter (three months) for eligible over-the-counter items.** No carryover from previous quarter(s). You must use the CVS Over-the-Counter program for this benefit. Member is responsible for the difference if the total exceeds the quarterly $105 allowance. The $105 quarterly allowance may only be exceeded at the retail locations. Orders placed over the phone or on the website must total $105 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.	**In-Network** $55 copay per day. **Out-of-Network** $70 copay per day.
Physician/Practitioner services, including doctor's office visits*	**In-Network**

Services that are covered for you	**What you must pay** when you get these services
Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment. • Certain additional telehealth services, including those rendered by a PCP, specialist, mental health care provider, or psychiatrist. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. **Members should call their provider first to inquire if telehealth services are available before seeking treatment.** o Telehealth services may be conducted by phone, computer, tablet and/or other video-enabled technology. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances	$0 copay per visit to a primary care provider. $40 copay per visit to a specialist. $40 copay for non-routine dental care. 20% coinsurance for therapeutic radiological services. 20% coinsurance for durable medical equipment, the cost of allergy serum, or other Part B drugs administered or dispensed in a physician's office. $40 copay for basic hearing and balance exam. $50 copay for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder, or foot). $0 to $60 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. $210 copay for diagnostic radiological PET scan services. $210 copay for all other diagnostic radiological services other than PET scan services. $10 copay for lab tests. $0 copay for PCP telehealth $40 copay for Specialist telehealth

Services that are covered for you	**What you must pay** when you get these services
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • 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.	$40 copay for Mental Health-Individual Sessions telehealth $40 copay for Psychiatric-Individual Sessions telehealth **Out-of-Network** $25 copay per visit to a primary care provider. $60 copay per visit to a specialist. 40% coinsurance for non-routine dental services. 40% coinsurance for therapeutic radiological services. 30% coinsurance for durable medical equipment, the cost of allergy serum or other Part B drugs administered or dispensed in a physician's office. $60 copay for basic hearing and balance exam. 40% coinsurance for X-rays (examples include but are not limited to a basic film X-ray of an ankle, shoulder or foot). 40% coinsurance 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. 40% coinsurance for diagnostic radiological services (advanced imaging examples include but are not limited to MRI, CT scan, and PET scan).

Services that are covered for you	**What you must pay** when you get these services
	$20 copay for lab tests. **In- and Out-of-Network** $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.
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.	**In-Network** $40 copay per visit. **Out-of-Network** $60 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.	**In- and Out-of-Network** $0 copay for covered meals** You must use GA Foods to receive this benefit. **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, age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for an annual PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2.1 for more information.	**In-Network** 20% coinsurance. **Out-of-Network** 30% coinsurance.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-Network** $20 copay per visit. **Out-of-Network** 40% coinsurance 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 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services
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.	
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 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as	**In-Network** $0 copay per visit for self-dialysis training if provided in a primary care provider's office. $40 copay per visit for self-dialysis training if provided in a specialist's office. 20% coinsurance per visit for outpatient dialysis treatments

Services that are covered for you	**What you must pay** when you get these services
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."	provided in an outpatient facility or an outpatient renal dialysis treatment center. 20% coinsurance for home dialysis equipment and supplies. $0 copay for home health support services. **Out-of-Network** $25 copay per visit for self-dialysis training if provided in a primary care provider's office. $60 copay per visit for self-dialysis training if provided in a specialist's office. 30% coinsurance per visit for outpatient dialysis treatments provided in an outpatient facility or an outpatient renal dialysis treatment center. 30% coinsurance for home dialysis equipment and supplies. **In-and Out-of-Network** $0 copay per visit for kidney disease education if provided in a primary care provider's office or a specialist's office (a copay will apply if you also are treated for an existing medical condition during the visit). No additional cost for dialysis treatments while admitted to a hospital.
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.")	**In-Network** $0 copay per day for days 1-20, per SNF stay

Services that are covered for you	**What you must pay** when you get these services
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. • 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.	$196 copay per day for days 21-58, per SNF stay $0 copay per day for days 59-100, per SNF stay **Out-of-Network** 50% coinsurance per skilled nursing facility stay. **In- and Out-of-Network** 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 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.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12-month period as a preventive service 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.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
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 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.	**In-Network** $20 copay per visit. **Out-of-Network** 40% coinsurance per visit.
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	**In- and Out-of-Network** $45 copay per urgent care visit within the U.S.

Services that are covered for you	**What you must pay** when you get these services
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. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Urgently needed services are covered worldwide.	$45 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.	**In- and Out-of-Network** $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-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	**In-Network** $0 copay for routine eye exam** (if a medical condition is found and/or treated during a routine eye exam, a copay may apply). $40 copay per visit for exams of the eye related to a medical condition. $0 copay for diabetic retinopathy screening for people with diabetes (if other diagnostic or therapeutic services are provided during the same visit, a copay may apply). $0 copay for Medicare-covered eyewear up to the Medicare allowable benefit following cataract surgery.

Services that are covered for you	**What you must pay** when you get these services
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 $150 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.	**Out-of-Network** $50 copay for routine eye exam** (if a medical condition is found and/or treated during a routine eye exam, a higher copay may apply). $50 copay per visit for exams of the eye related to a medical condition. $50 copay for diabetic retinopathy screening for people with diabetes (if other diagnostic or therapeutic services are provided during the same visit, a higher copay may apply). 40% coinsurance for Medicare-covered eyewear up to the Medicare allowable benefit following cataract surgery. **In-and Out-of-Network** $150 allowance for non-Medicare covered eyewear every year, including contact lenses eyeglasses (lenses and/or frames). You must use a Spectera contracted provider to access this benefit. There is no coinsurance, copayment or deductible for eligible beneficiaries for the Medicare-covered glaucoma screening. **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.

Services that are covered for you	**What you must pay** when you get these services
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 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.	**In- and Out-of-Network** There is a $1,500 allowance toward visitor/travel covered, medically necessary services from out-of-network providers at in-network cost sharing when traveling outside the state of Ohio. Amounts do not carry over from year to year.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In- and Out-of-Network** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

MediGold PPO Dental
Deductible: $0 Combined Annual Plan Maximum: $1,000 Out of Network Allowance: Maximum Allowable Charges

MediGold PPO Dental				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	Periodic Oral Evaluation	0%	0%	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%	0%	2 per calendar year
D0160	Detailed and extensive oral evaluation - problem-focused, by report	0%	0%	2 per calendar year
D0180	Comprehensive periodontal evaluation - new or established patient	0%	0%	2 per calendar year
D0190	Screening of a patient	0%	0%	Unlimited
D0210	Intraoral - Complete Series Of Radiographic Images	0%	0%	1 per consecutive 36 months
D0220	Intraoral - Periapical First Radiographic Image	0%	0%	8 per calendar year
D0230	Intraoral - Periapical Each Additional Radiographic Image	0%	0%	8 per calendar year
D0240	Intraoral - Occlusal Radiographic Image	0%	0%	2 per consecutive 6 months
D0250	Extraoral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	0%	0%	2 per calendar year
D0270	Bitewing - Single Radiographic Image	0%	0%	8 per calendar year
D0272	Bitewings - Two Radiographic Images	0%	0%	4 per calendar year
D0273	Bitewings - Three Radiographic Images	0%	0%	2 per calendar year
D0274	Bitewings - Four Radiographic Images	0%	0%	2 per calendar year
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0%	0%	1 per consecutive 36 months
D0330	Panoramic Radiographic Image	0%	0%	1 per consecutive 36 months
D0701	D0701-panoramic radiographic image – image capture only	0%	0%	1 per consecutive 36 months

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D0702	D0702-2-D cephalometric radiographic image – image capture only	0%	0%	1 per consecutive 36 months
D0706	D0706-intraoral – occlusal radiographic image – image capture only	0%	0%	2 per consecutive 6 months
D0707	D0707-intraoral – periapical radiographic image – image capture only	0%	0%	8 per calendar year
D0708	D0708-intraoral – bitewing radiographic image – image capture only	0%	0%	8 per calendar year
D0709	D0709-intraoral – complete series of radiographic images – image capture only	0%	0%	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	0%	Unlimited
Preventive				
D1110	Prophylaxis - Adult	0%	0%	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	0%	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	0%	2 per calendar year
D1510	Space Maintainer - Fixed - Unilateral	0%	0%	1 per consecutive 60 months
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	0%	0%	1 per consecutive 60 months
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	0%	0%	1 per consecutive 60 months
D1520	Space Maintainer - Removable - Unilateral	0%	0%	1 per consecutive 60 months
D1526	Space Maintainer – Removable – Bilateral, Maxillary	0%	0%	1 per consecutive 60 months
D1527	Space Maintainer – Removable – Bilateral, Mandibular	0%	0%	1 per consecutive 60 months
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	0%	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	0%	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	0%	1 per consecutive 6 months

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D1556	removal of fixed unilateral space maintainer - per quadrant	0%	0%	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	0%	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	0%	Unlimited
D1575	Distal Shoe Space Maintainer - Fixed Unilateral	0%	0%	1 per consecutive 60 months
D1999	Unspecified preventive procedure, by report	0%	0%	Unlimited
Restorative				
D2140	Amalgam - One Surface, Primary Or Permanent	50%	50%	Unlimited
D2150	Amalgam - Two Surfaces, Primary Or Permanent	50%	50%	Unlimited
D2160	Amalgam - Three Surfaces, Primary Or Permanent	50%	50%	Unlimited
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	50%	50%	Unlimited
D2330	Resin-Based Composite - One Surface, Anterior	50%	50%	Unlimited
D2331	Resin-Based Composite - Two Surfaces, Anterior	50%	50%	Unlimited
D2332	Resin-Based Composite - Three Surfaces, Anterior	50%	50%	Unlimited
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	50%	50%	Unlimited
D2390	Resin-Based Composite Crown, Anterior	50%	50%	1 per consecutive 60 months
D2391	Resin-Based Composite - One Surface, Posterior	50%	50%	Unlimited
D2392	Resin-Based Composite - Two Surfaces, Posterior	50%	50%	Unlimited
D2393	Resin-Based Composite - Three Surfaces, Posterior	50%	50%	Unlimited
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	50%	50%	Unlimited
D2910	Recement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	50%	50%	1 per consecutive 12 months

MediGold PPO Dental				
D2915	Recement Or Re-Bond Cast Indirectly Fabricated Or Prefabricated Post And Core	50%	50%	1 per consecutive 12 months
D2920	Recement Or Re-Bond Crown	50%	50%	1 per consecutive 12 months
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	50%	50%	1 per consecutive 6 months
D2940	Protective Restoration	50%	50%	Unlimited
D2941	Interim Therapeutic Restoration-Primary Dentition	50%	50%	Unlimited
D2951	Pin Retention - Per Tooth, In Addition To Restoration	50%	50%	1 per consecutive 60 months
D2980	Crown Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2981	Inlay Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2982	Onlay Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	50%	Unlimited
Endodontics				
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime
D3221	Pulpal Debridement, Primary And Permanent Teeth	70%	70%	1 per tooth per lifetime
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth With Incomplete Root Development	70%	70%	1 per tooth per lifetime
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	70%	70%	1 per tooth per lifetime

MediGold PPO Dental				
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	70%	70%	1 per tooth per lifetime
D3333	Internal Tooth Repair Of Performation Defects	70%	70%	1 per tooth per lifetime
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	70%	70%	1 per tooth per lifetime
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	70%	70%	1 per tooth per lifetime
D3348	Retreatment Of Previous Root Canal Therapy - Molar	70%	70%	1 per tooth per lifetime
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc	70%	70%	1 per tooth per lifetime
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	70%	70%	1 per tooth per lifetime
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root	70%	70%	1 per tooth per lifetime
D3410	Apicoectomy - Anterior	70%	70%	1 per tooth per lifetime
D3421	Apicoectomy - Premolar (First Root)	70%	70%	1 per tooth per lifetime
D3425	Apicoectomy - Molar (First Root)	70%	70%	1 per tooth per lifetime
D3426	Apicoectomy (Each Additional Root)	70%	70%	2 per tooth per lifetime
D3430	Retrograde Filling - Per Root	70%	70%	1 per tooth per lifetime
D3450	Root Amputation - Per Root	70%	70%	1 per tooth per lifetime
D3471	D3471-surgical repair of root resorption - anterior	70%	70%	1 per tooth per lifetime
D3472	D3472-surgical repair of root resorption – premolar	70%	70%	1 per tooth per lifetime
D3473	D3473-surgical repair of root resorption – molar	70%	70%	1 per tooth per lifetime
D3501	D3501-surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	70%	70%	1 per tooth per lifetime
D3502	D3502-surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	70%	70%	1 per tooth per lifetime

MediGold PPO Dental				
D3503	D3503-surgical exposure of root surface without apicoectomy or repair of root resorption – molar	70%	70%	1 per tooth per lifetime
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	70%	70%	1 per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	70%	70%	Unlimited
Periodontics				
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	70%	1 per quadrant per consecutive 36 months
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	70%	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%	70%	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%	70%	1 per quadrant per consecutive 36 months
D4245	Apically Positioned Flap	70%	70%	1 per quadrant per consecutive 36 months
D4249	Clinical Crown Lengthening - Hard Tissue	70%	70%	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%	70%	1 per quadrant per consecutive 36 months
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	70%	70%	1 per quadrant per consecutive 36 months
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	70%	70%	1 per consecutive 36 months
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	70%	70%	1 per consecutive 36 months

MediGold PPO Dental				
D4265	Biologic Materials To Aid In Soft And Osseous Tissue Regeneration	70%	70%	1 per consecutive 36 months
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	70%	70%	1 per consecutive 36 months
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	70%	70%	1 per consecutive 36 months
D4268	Surgical Revision Procedure, Per Tooth	70%	70%	1 per consecutive 36 months
D4270	Pedicle Soft Tissue Graft Procedure	70%	70%	1 per consecutive 36 months
D4273	Autogenous Connective Tissue Graft Procedure, Per First Tooth, Implant Or Endentulous Tooth Position In Graft	70%	70%	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%	70%	1 per consecutive 36 months
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant	70%	70%	1 per consecutive 36 months
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	70%	70%	1 per consecutive 36 months
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites)First Tooth, Implant, Or Edentulous Tooth	70%	70%	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	70%	70%	1 per consecutive 36 months
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	70%	70%	1 per consecutive 36 months
D4285	Non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	70%	70%	1 per consecutive 36 months
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	70%	70%	1 per quadrant per consecutive 24 months

MediGold PPO Dental				
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	70%	70%	1 per quadrant per consecutive 24 months
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation	70%	70%	2 per consecutive 12 months
D4355	Full Mouth Debridement To Enable A Comprehensive Oral Evaluation And Diagnosis On A Subsequent Visit	70%	70%	1 per consecutive 36 months
D4910	Periodontal Maintenance	70%	70%	2 per calendar year
D4999	Unspecified periodontal procedure, by report	70%	70%	Unlimited
Oral & Maxillofacial Surgery				
D7111	Extraction, Coronal Remnants - Primary Tooth	50%	50%	1 per tooth per lifetime
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	50%	50%	1 per tooth per lifetime
D7210	Extraction, Erupted Tooth Req Removal Of Bone,Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap	50%	50%	1 per tooth per lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	50%	50%	1 per tooth per lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	50%	50%	1 per tooth per lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	50%	50%	1 per tooth per lifetime
D7241	Removal Of Impacted Tooth - Completely Bony, With Unusual Surgical	50%	50%	1 per tooth per lifetime
D7250	Removal Of Residual Tooth Roots (Cutting Procedure)	50%	50%	1 per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	50%	Unlimited
D7270	Tooth Reimplantation And/Or Stabilization Of Accidentally Evulsed Or Displaced Tooth	50%	50%	1 per site per lifetime
D7280	Exposure Of An Unerupted Tooth	50%	50%	1 per tooth per lifetime

MediGold PPO Dental				
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	50%	50%	1 per tooth per lifetime
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	50%	50%	1 per tooth per lifetime
D7286	Incisional Biopsy Of Oral Tissue - Soft (All Others)	50%	50%	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	50%	Unlimited
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	50%	50%	1 per tooth per lifetime
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	50%	Unlimited
D7311	Alveoplasty In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	50%	Unlimited
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	50%	50%	Unlimited
D7321	Alveoplasty Not In Conjunction With Extraction - One To Three Teeth Or Tooth Spaces, Per Quadrant	50%	50%	Unlimited
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	50%	50%	1 per site per visit
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Fascial Spaces)	50%	50%	1 per site per visit
D7910	Suture of recent small wounds up to 5 cm	50%	50%	Unlimited
D7970	Excision Of Hyperplastic Tissue - Per Arch	50%	50%	1 per site per consecutive 36 months
D7971	Excision Of Pericoronal Gingiva	50%	50%	1 per site per consecutive 36 months
D7999	Unspecified oral surgery procedure, by report	50%	50%	Unlimited
Adjunctive General Services				
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0%	0%	Unlimited

MediGold PPO Dental				
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,
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. • 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. PPO members who separately purchase the Optional Supplemental Dental benefit may receive both preventive and comprehensive care from a MediGold Dental network provider or an out-of-network provider. Services received from providers who do NOT participate in the MediGold Dental network may result in higher out-of-pocket costs. Dental benefits are administered by Dental Benefit Providers.	**In-and Out-of-Network** $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
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 **$43** 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. • 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. PPO members who separately purchase the Optional Supplemental Dental benefit may receive both preventive and comprehensive care from a MediGold Dental network provider or an out-of-network provider. Services received from providers who do NOT participate in the MediGold Dental network may result in higher out-of-pocket costs. Dental benefits are administered by Dental Benefit Providers.	**In-and Out-of-Network** $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.

MediGold PPO Dental Silver				
Deductible: $0 Combined Annual Plan Maximum: $1,500 Out of Network Allowance: Maximum Allowable Charges				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	Periodic Oral Evaluation	0%	0%	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%	0%	2 per calendar year
D0160	Detailed and extensive oral evaluation - problem-focused, by report	0%	0%	2 per calendar year
D0180	Comprehensive periodontal evaluation - new or established patient	0%	0%	2 per calendar year
D0190	Screening of a patient	0%	0%	Unlimited
D0210	Intraoral - Complete Series Of Radiographic Images	0%	0%	1 per consecutive 36 months
D0220	Intraoral - Periapical First Radiographic Image	0%	0%	8 per calendar year
D0230	Intraoral - Periapical Each Additional Radiographic Image	0%	0%	8 per calendar year
D0240	Intraoral - Occlusal Radiographic Image	0%	0%	2 per consecutive 6 months
D0250	Extraoral - 2D Projection Radiographic Image Created Using A Stationary Radiation Source And Detector	0%	0%	2 per calendar year
D0270	Bitewing - Single Radiographic Image	0%	0%	8 per calendar year
D0272	Bitewings - Two Radiographic Images	0%	0%	4 per calendar year
D0273	Bitewings - Three Radiographic Images	0%	0%	2 per calendar year
D0274	Bitewings - Four Radiographic Images	0%	0%	2 per calendar year

MediGold PPO Dental Silver				
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0%	0%	1 per consecutive 36 months
D0330	Panoramic Radiographic Image	0%	0%	1 per consecutive 36 months
D0701	D0701-panoramic radiographic image – image capture only	0%	0%	1 per consecutive 36 months
D0702	D0702-2-D cephalometric radiographic image – image capture only	0%	0%	1 per consecutive 36 months
D0706	D0706-intraoral – occlusal radiographic image – image capture only	0%	0%	2 per consecutive 6 months
D0707	D0707-intraoral – periapical radiographic image – image capture only	0%	0%	8 per calendar year
D0708	D0708-intraoral – bitewing radiographic image – image capture only	0%	0%	8 per calendar year
D0709	D0709-intraoral – complete series of radiographic images – image capture only	0%	0%	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	0%	Unlimited
Preventive				
D1110	Prophylaxis - Adult	0%	0%	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	0%	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	0%	2 per calendar year
D1510	Space Maintainer - Fixed - Unilateral	0%	0%	1 per consecutive 60 months
D1516	Space Maintainer – Fixed – Bilateral, Maxillary	0%	0%	1 per consecutive 60 months
D1517	Space Maintainer – Fixed – Bilateral, Mandibular	0%	0%	1 per consecutive 60 months
D1520	Space Maintainer - Removable - Unilateral	0%	0%	1 per consecutive 60 months
D1526	Space Maintainer – Removable – Bilateral, Maxillary	0%	0%	1 per consecutive 60 months
D1527	Space Maintainer – Removable – Bilateral, Mandibular	0%	0%	1 per consecutive 60 months

MediGold PPO Dental Silver				
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	0%	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	0%	1 per consecutive 6 months
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	0%	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	0%	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	0%	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	0%	Unlimited
D1575	Distal Shoe Space Maintainer - Fixed Unilateral	0%	0%	1 per consecutive 60 months
D1999	Unspecified preventive procedure, by report	0%	0%	Unlimited
Restorative				
D2140	Amalgam - One Surface, Primary Or Permanent	0%	0%	Unlimited
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0%	0%	Unlimited
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0%	0%	Unlimited
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0%	0%	Unlimited
D2330	Resin-Based Composite - One Surface, Anterior	0%	0%	Unlimited
D2331	Resin-Based Composite - Two Surfaces, Anterior	0%	0%	Unlimited
D2332	Resin-Based Composite - Three Surfaces, Anterior	0%	0%	Unlimited
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	0%	0%	Unlimited
D2390	Resin-Based Composite Crown, Anterior	50%	50%	1 per consecutive 60 months
D2391	Resin-Based Composite - One Surface, Posterior	0%	0%	Unlimited
D2392	Resin-Based Composite - Two Surfaces, Posterior	0%	0%	Unlimited
D2393	Resin-Based Composite - Three Surfaces, Posterior	0%	0%	Unlimited

MediGold PPO Dental Silver				
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0%	0%	Unlimited
D2910	Recement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	50%	50%	1 per consecutive 12 months
D2915	Recement Or Re-Bond Cast Indirectly Fabricated Or Prefabricated Post And Core	50%	50%	1 per consecutive 12 months
D2920	Recement Or Re-Bond Crown	50%	50%	1 per consecutive 12 months
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	50%	50%	1 per consecutive 6 months
D2940	Protective Restoration	50%	50%	Unlimited
D2941	Interim Therapeutic Restoration-Primary Dentition	50%	50%	Unlimited
D2951	Pin Retention - Per Tooth, In Addition To Restoration	50%	50%	1 per consecutive 60 months
D2980	Crown Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2981	Inlay Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2982	Onlay Repair Necessitated By Restorative Material Failure	50%	50%	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	50%	Unlimited
Endodontics				
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	50%	50%	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%	50%	1 per tooth per lifetime
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	50%	50%	1 per tooth per lifetime
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	50%	50%	1 per tooth per lifetime

MediGold PPO Dental Silver				
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	50%	50%	1 per tooth per lifetime
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	50%	50%	1 per tooth per lifetime
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	50%	50%	1 per tooth per lifetime
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable Or Fractured Tooth	50%	50%	1 per tooth per lifetime
D3333	Internal Tooth Repair Of Performation Defects	50%	50%	1 per tooth per lifetime
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	50%	50%	1 per tooth per lifetime
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	50%	50%	1 per tooth per lifetime
D3348	Retreatment Of Previous Root Canal Therapy - Molar	50%	50%	1 per tooth per lifetime
D3351	Apexification/Recalcification-Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc	50%	50%	1 per tooth per lifetime
D3352	Apexification/Recalcification/Pulpal Regeneration - Interim Medication Replacement	50%	50%	1 per tooth per lifetime
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root	50%	50%	1 per tooth per lifetime
D3410	Apicoectomy - Anterior	50%	50%	1 per tooth per lifetime
D3421	Apicoectomy - Premolar (First Root)	50%	50%	1 per tooth per lifetime
D3425	Apicoectomy - Molar (First Root)	50%	50%	1 per tooth per lifetime
D3426	Apicoectomy (Each Additional Root)	50%	50%	2 per tooth per lifetime
D3430	Retrograde Filling - Per Root	50%	50%	1 per tooth per lifetime
D3450	Root Amputation - Per Root	50%	50%	1 per tooth per lifetime
D3471	D3471-surgical repair of root resorption - anterior	50%	50%	1 per tooth per lifetime
D3472	D3472-surgical repair of root resorption – premolar	50%	50%	1 per tooth per lifetime

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

MediGold PPO Dental Silver				
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Tooth Bounded Spaces Per Quadrant	50%	50%	1 per quadrant per consecutive 36 months
D4263	Bone Replacement Graft - Retained Natural Tooth - First Site In Quadrant	50%	50%	1 per consecutive 36 months
D4264	Bone Replacement Graft - Retained Natural Tooth - Each Additional Site In Quadrant	50%	50%	1 per consecutive 36 months
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	50%	50%	1 per consecutive 36 months
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	50%	50%	1 per consecutive 36 months
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	50%	50%	1 per consecutive 36 months
D4268	Surgical Revision Procedure, Per Tooth	50%	50%	1 per consecutive 36 months
D4270	Pedicle Soft Tissue Graft Procedure	50%	50%	1 per consecutive 36 months
D4273	Autogenous Connective Tissue Graft Procedure, Per First Tooth, Implant Or Endentulous Tooth Position In Graft	50%	50%	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%	50%	1 per consecutive 36 months
D4275	Non-Autogenous Connective Tissue Graft (Including Recipient Site And Donor Material) First Tooth Implant	50%	50%	1 per consecutive 36 months
D4276	Combined connective tissue and pedicle graft, per tooth	50%	50%	1 per consecutive 36 months
D4277	Free Soft Tissue Graft Procedure (Including Recipient And Donor Surgical Sites)First Tooth, Implant, Or Edentulous Tooth	50%	50%	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	50%	50%	1 per consecutive 36 months

MediGold PPO Dental Silver				
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50%	1 per consecutive 36 months
D4285	Non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50%	1 per consecutive 36 months
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	50%	50%	1 per quadrant per consecutive 24 months
D4342	Periodontal Scaling And Root Planing - One - Three Teeth, Per Quadrant	50%	50%	1 per quadrant per consecutive 24 months
D4346	Scaling In Presence Of Generalized Moderate Or Severe Gingival Inflammation	50%	50%	2 per consecutive 12 months
D4355	Full Mouth Debridement To Enable A Comprehensive Oral Evaluation And Diagnosis On A Subsequent Visit	50%	50%	1 per consecutive 36 months
D4910	Periodontal Maintenance	50%	50%	2 per calendar year
D4999	Unspecified periodontal procedure, by report	50%	50%	Unlimited
Oral & Maxillofacial Surgery				
D7111	Extraction, Coronal Remnants - Primary Tooth	50%	50%	1 per tooth per lifetime
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	50%	50%	1 per tooth per lifetime
D7210	Extraction, Erupted Tooth Req Removal Of Bone, Sectioning Of Tooth And Including Elevation Of Mucoperiosteal Flap	50%	50%	1 per tooth per lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	50%	50%	1 per tooth per lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	50%	50%	1 per tooth per lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	50%	50%	1 per tooth per lifetime

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

MediGold PPO Dental Silver				
D7910	Suture of recent small wounds up to 5 cm	50%	50%	Unlimited
D7970	Excision Of Hyperplastic Tissue - Per Arch	50%	50%	1 per site per consecutive 36 months
D7971	Excision Of Pericoronal Gingiva	50%	50%	1 per site per consecutive 36 months
D7999	Unspecified oral surgery procedure, by report	50%	50%	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%	50%	1 per consecutive 6 months
D9948	adjustment of custom sleep apnea appliance	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 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 PPO Dental Gold				
Deductible: $0 Combined Annual Plan Maximum: $2,000 Out of Network Allowance: Maximum Allowable Charges				
ADA Code	**Procedure Description**	**In Network Coinsurance**	**Out of Network Coinsurance**	**Frequency Limit**
Diagnostic				
D0120	periodic oral evaluation	0%	0%	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%	0%	2 per calendar year
D0160	detailed and extensive oral evaluation - problem-focused, by report	0%	0%	2 per calendar year
D0170	re-evaluation, limited, problem focused	0%	0%	2 per calendar year
D0180	comprehensive periodontal evaluation - new or established patient	0%	0%	2 per calendar year
D0190	Screening of a patient	0%	0%	Unlimited
D0210	intraoral - complete series of radiographic images	0%	0%	1 per consecutive 36 months
D0220	intraoral - periapical first radiographic image	0%	0%	8 per calendar year
D0230	intraoral - periapical each additional radiographic image	0%	0%	8 per calendar year
D0240	intraoral - occlusal radiographic image	0%	0%	2 per consecutive 6 months
D0250	extraoral - 2D projection radiographic image created using a stationary radiation source and detector	0%	0%	2 per calendar year
D0251	extra-oral posterior dental radiographic image	0%	0%	2 per calendar year
D0270	bitewing - single radiographic image	0%	0%	8 per calendar year
D0272	bitewings - two radiographic images	0%	0%	4 per calendar year

MediGold PPO Dental Gold				
D0273	bitewings - three radiographic images	0%	0%	2 per calendar year
D0274	bitewings - four radiographic images	0%	0%	2 per calendar year
D0277	vertical bitewings - 7 to 8 radiographic images	0%	0%	1 per consecutive 36 months
D0330	panoramic radiographic image	0%	0%	1 per consecutive 36 months
D0350	2D Oral/facial photographic images obtained intraorally or extraorally	0%	0%	1 per consecutive 36 months
D0351	3D photographic image	0%	0%	1 per consecutive 36 months
D0364	cone beam CT capture and interpretation with limited field of view - less than one whole jaw	50%	50%	1 per consecutive 60 months
D0365	cone beam CT capture and interpretation with field of view of one full dental arch - mandible	50%	50%	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%	50%	1 per consecutive 60 months
D0367	cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	50%	50%	1 per consecutive 60 months
D0411	HbA1c in office point of service testing	0%	0%	No frequency limitation
D0414	Lab processing of microbial specimen to include culture and sensitivity studies.	0%	0%	No frequency limitation
D0415	collection of microorganisms for culture and sensitivity	0%	0%	No frequency limitation
D0416	viral culture	0%	0%	No frequency limitation
D0417	collection and preparation of saliva sample for laboratory diagnostic testing	0%	0%	No frequency limitation
D0418	analysis of saliva sample	0%	0%	No frequency limitation
D0422	collection and preparation of genetic sample material for laboratory analysis and report	0%	0%	No frequency limitation

MediGold PPO Dental Gold				
D0423	genetic test for susceptibility to diseases-specimen analysis	0%	0%	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%	0%	1 per consecutive 12 months
D0460	pulp vitality tests	0%	0%	1 charge per visit, regardless of how many teeth are tested.
D0470	diagnostic casts	0%	0%	1 per consecutive 24 months
D0600	non-ionizing diagnostic procedure	0%	0%	No frequency limitation
D0601	caries risk assessment and documentation, with a finding of low risk	0%	0%	2 per consecutive 12 months
D0602	caries risk assessment and documentation, with a finding of moderate risk	0%	0%	2 per consecutive 12 months
D0603	caries risk assessment and documentation, with a finding of high risk	0%	0%	2 per consecutive 12 months
D0604	antigen testing for a public health related pathogen, including coronavirus	0%	0%	Unlimited
D0605	antibody testing for a public health related pathogen, including coronavirus	0%	0%	Unlimited
D0606	molecular testing for public health related pathogen, including coronavirus	0%	0%	Unlimited
D0701	panoramic radiographic image – image capture only	0%	0%	1 per consecutive 36 months
D0702	2-D cephalometric radiographic image – image capture only	0%	0%	1 per consecutive 36 months
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	0%	0%	1 per consecutive 36 months
D0704	3-D photographic image – image capture only	0%	0%	1 per consecutive 36 months

MediGold PPO Dental Gold				
D0705	extra-oral posterior dental radiographic image – image capture only	0%	0%	2 per calendar year
D0706	intraoral – occlusal radiographic image – image capture only	0%	0%	2 per consecutive 6 months
D0707	intraoral – periapical radiographic image – image capture only	0%	0%	8 per calendar year
D0708	intraoral – bitewing radiographic image – image capture only	0%	0%	8 per calendar year
D0709	intraoral – complete series of radiographic images – image capture only	0%	0%	1 per consecutive 36 months
D0999	Unspecified diagnostic procedure, by report	0%	0%	Unlimited
Preventive				
D1110	prophylaxis - adult	0%	0%	2 per calendar year
D1206	Topical Application Of Fluoride Varnish	0%	0%	2 per calendar year
D1208	Topical Application Of Fluoride - Excluding Varnish	0%	0%	2 per calendar year
D1354	application of caries arresting medicament – per tooth	0%	0%	No frequency limitation
D1355	caries preventive medicament application – per tooth	0%	0%	2 per consecutive 12 months
D1510	space maintainer - fixed, unilateral - per quadrant	0%	0%	1 per consecutive 60 months
D1516	space maintainer - fixed - bilateral, maxillary	0%	0%	1 per consecutive 60 months
D1517	space maintainer - fixed - bilateral, mandibular	0%	0%	1 per consecutive 60 months
D1520	space maintainer - removable, unilateral - per quadrant	0%	0%	1 per consecutive 60 months
D1526	space maintainer - removable - bilateral, maxillary	0%	0%	1 per consecutive 60 months
D1527	space maintainer - removable - bilateral, mandibular	0%	0%	1 per consecutive 60 months
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0%	0%	1 per consecutive 6 months
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0%	0%	1 per consecutive 6 months

MediGold PPO Dental Gold				
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0%	0%	1 per consecutive 6 months
D1556	removal of fixed unilateral space maintainer - per quadrant	0%	0%	Unlimited
D1557	removal of fixed bilateral space maintainer - maxillary	0%	0%	Unlimited
D1558	removal of fixed bilateral space maintainer - mandibular	0%	0%	Unlimited
D1575	distal shoe space maintainer - fixed, unilateral - per quadrant	0%	0%	1 per consecutive 60 months
D1701	Pfizer-BioNTech Covid-19 vaccine administration - first dose	0%	0%	Unlimited
D1702	Pfizer-BioNTech Covid-19 vaccine administration - second dose	0%	0%	Unlimited
D1703	Moderna Covid-19 vaccine administration - first dose	0%	0%	Unlimited
D1704	Moderna Covid-19 vaccine administration - second dose	0%	0%	Unlimited
D1705	AstraZeneca Covid-19 vaccine administration - first dose	0%	0%	Unlimited
D1706	AstraZeneca Covid-19 vaccine administration - second dose	0%	0%	Unlimited
D1707	Janssen Covid-19 vaccine administration	0%	0%	Unlimited
D1999	Unspecified preventive procedure, by report	0%	0%	Unlimited
Restorative				
D2140	amalgam - one surface, primary or permanent	0%	0%	No frequency limitation
D2150	amalgam - two surfaces, primary or permanent	0%	0%	No frequency limitation
D2160	amalgam - three surfaces, primary or permanent	0%	0%	No frequency limitation
D2161	amalgam - four or more surfaces, primary or permanent	0%	0%	No frequency limitation
D2330	resin-based composite - one surface, anterior	0%	0%	No frequency limitation
D2331	resin-based composite - two surfaces, anterior	0%	0%	No frequency limitation
D2332	resin-based composite - three surfaces, anterior	0%	0%	No frequency limitation

MediGold PPO Dental Gold				
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0%	0%	No frequency limitation
D2390	resin-based composite crown, anterior	0%	0%	1 per consecutive 60 months
D2391	resin-based composite - one surface, posterior	0%	0%	No frequency limitation
D2392	resin-based composite - two surfaces, posterior	0%	0%	No frequency limitation
D2393	resin-based composite - three surfaces, posterior	0%	0%	No frequency limitation
D2394	resin-based composite - four or more surfaces, posterior	0%	0%	No frequency limitation
D2410	gold foil - one surface	50%	50%	No frequency limitation
D2420	gold foil - two surfaces	50%	50%	No frequency limitation
D2430	gold foil - three surfaces	50%	50%	No frequency limitation
D2510	inlay - metallic - one surface	50%	50%	1 per consecutive 60 months
D2520	inlay - metallic - two surfaces	50%	50%	1 per consecutive 60 months
D2530	inlay - metallic - three or more surfaces	50%	50%	1 per consecutive 60 months
D2542	onlay metallic, two surfaces	50%	50%	1 per consecutive 60 months
D2543	onlay-metallic-three surfaces	50%	50%	1 per consecutive 60 months
D2544	onlay-metallic-four or more surfaces	50%	50%	1 per consecutive 60 months
D2610	inlay - porcelain/ceramic - one surface	50%	50%	1 per consecutive 60 months
D2620	inlay - porcelain/ceramic - two surfaces	50%	50%	1 per consecutive 60 months
D2630	inlay - porcelain/ceramic - three or more surfaces	50%	50%	1 per consecutive 60 months
D2642	onlay - porcelain/ceramic - two surfaces	50%	50%	1 per consecutive 60 months
D2643	onlay - porcelain/ceramic - three surfaces	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
D2644	onlay - porcelain/ceramic - four or more surfaces	50%	50%	1 per consecutive 60 months
D2650	inlay - composite/resin - one surface	50%	50%	1 per consecutive 60 months
D2651	inlay - composite/resin - two surfaces	50%	50%	1 per consecutive 60 months
D2652	inlay - composite/resin - three or more surfaces	50%	50%	1 per consecutive 60 months
D2662	onlay - composite/resin - two surfaces	50%	50%	1 per consecutive 60 months
D2663	onlay - composite/resin - three surfaces	50%	50%	1 per consecutive 60 months
D2664	onlay - composite/resin - four or more surfaces	50%	50%	1 per consecutive 60 months
D2710	crown,resin-based composite (indirect)	50%	50%	1 per consecutive 60 months
D2712	crown - 3/4 resin-based composite (indirect)	50%	50%	1 per consecutive 60 months
D2720	crown - resin with high noble metal	50%	50%	1 per consecutive 60 months
D2721	crown - resin with predominantly base metal	50%	50%	1 per consecutive 60 months
D2722	crown - resin with noble metal	50%	50%	1 per consecutive 60 months
D2740	crown - porcelain/ceramic	50%	50%	1 per consecutive 60 months
D2750	crown - porcelain fused to high noble metal	50%	50%	1 per consecutive 60 months
D2751	crown - porcelain fused to predominantly base metal	50%	50%	1 per consecutive 60 months
D2752	crown - porcelain fused to noble metal	50%	50%	1 per consecutive 60 months
D2780	crown, 3/4 cast high noble metal	50%	50%	1 per consecutive 60 months
D2781	crown, 3/4 cast predominately base metal	50%	50%	1 per consecutive 60 months
D2782	crown, 3/4 cast noble metal	50%	50%	1 per consecutive 60 months
D2783	crown, 3/4 porcelain/ceramic	50%	50%	1 per consecutive 60 months
D2790	crown - full cast high noble metal	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
D2791	crown - full cast predominantly base metal	50%	50%	1 per consecutive 60 months
D2792	crown - full cast noble metal	50%	50%	1 per consecutive 60 months
D2794	crown - titanium	50%	50%	1 per consecutive 60 months
D2799	interim crown – further treatment or completion of diagnosis necessary prior to final impression	50%	50%	1 per consecutive 60 months
D2910	recement or re-bond inlay, onlay, veneer or partial coverage restoration	50%	50%	1 per consecutive 12 months
D2915	recement or re-bond cast indirectly fabricated or prefabricated post and core	50%	50%	1 per consecutive 12 months
D2920	recement or re-bond crown	50%	50%	1 per consecutive 12 months
D2921	reattachment of tooth fragment, incisal edge or cusp	50%	50%	1 per consecutive 6 months
D2930	prefabricated stainless steel crown - primary tooth	50%	50%	1 per consecutive 60 months
D2931	prefabricated stainless steel crown - permanent tooth	50%	50%	1 per consecutive 60 months
D2932	prefabricated resin crown	50%	50%	1 per consecutive 60 months
D2933	prefabricated stainless steel crown with resin window	50%	50%	1 per consecutive 60 months
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	50%	50%	1 per consecutive 60 months
D2940	protective restoration	50%	50%	No frequency limitation
D2941	interim therapeutic restoration-primary dentition	50%	50%	No frequency limitation
D2950	Core buildup, including any pins when required	50%	50%	1 per consecutive 60 months
D2951	pin retention - per tooth, in addition to restoration	50%	50%	1 per consecutive 60 months
D2952	cast post and core in addition to crown	50%	50%	1 per consecutive 60 months
D2953	each additional indirectly fabricated post, same tooth	50%	50%	1 per consecutive 60 months
D2954	prefabricated post and core in addition to crown	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
D2957	each additional prefabricated post, same tooth	50%	50%	1 per consecutive 60 months
D2960	labial veneer (laminate) - chairside	50%	50%	1 per consecutive 60 months
D2961	labial veneer (resin laminate) - laboratory	50%	50%	1 per consecutive 60 months
D2962	labial veneer (porcelain laminate) - laboratory	50%	50%	1 per consecutive 60 months
D2975	coping	50%	50%	1 per consecutive 60 months
D2980	crown repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2981	inlay repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2982	onlay repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2983	Veneer repair necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
D2999	Unspecified restorative procedure, by report	50%	50%	Unlimited
Endodontics				
D3110	pulp cap - direct (excluding final restoration)	50%	50%	No frequency limitation
D3120	pulp cap - indirect (excluding final restoration)	50%	50%	No frequency limitation
D3220	therapeutic pulpotomy (excluding final restoration)	50%	50%	1 time per primary or 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%	50%	1 time per primary or secondary tooth per lifetime
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	50%	50%	1 time per tooth per lifetime. Covered for anterior or posterior teeth only

MediGold PPO Dental Gold				
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%	1 time per tooth per lifetime. Covered for anterior or posterior teeth only
D3310	endodontic therapy, anterior tooth (excluding final restoration)	50%	50%	1 time per tooth per lifetime
D3320	endodontic therapy, premolar tooth (excluding final restoration)	50%	50%	1 time per tooth per lifetime
D3330	endodontic therapy, molar tooth (excluding final restoration)	50%	50%	1 time per tooth per lifetime
D3331	treatment of root canal obstruction, non-surgical access	50%	50%	1 time per tooth per lifetime
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	50%	1 time per tooth per lifetime
D3333	internal tooth repair of performation defects	50%	50%	1 time per tooth per lifetime
D3346	retreatment of previous root canal therapy - anterior	50%	50%	1 time per tooth per lifetime
D3347	retreatment of previous root canal therapy - bicuspid	50%	50%	1 time per tooth per lifetime
D3348	retreatment of previous root canal therapy - molar	50%	50%	1 time per tooth per lifetime
D3351	Apexification/recalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc	50%	50%	1 time per tooth per lifetime
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	50%	50%	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%	50%	1 time per tooth per lifetime
D3355	Pupal regeneration-initial visit	50%	50%	1 time per tooth per lifetime
D3356	Pulpal regeneration-interim medicament replacement	50%	50%	1 time per tooth per lifetime
D3357	Pulpal regeneration-completion of treatment	50%	50%	1 time per tooth per lifetime

MediGold PPO Dental Gold				
D3410	Apicoectomy - anterior	50%	50%	1 time per tooth per lifetime
D3421	Apicoectomy - premolar (first root)	50%	50%	1 time per tooth per lifetime
D3425	Apicoectomy - molar (first root)	50%	50%	1 time per tooth per lifetime
D3426	Apicoectomy (each additional root)	50%	50%	2 times per tooth per lifetime
D3430	retrograde filling - per root	50%	50%	1 time per tooth per lifetime
D3450	root amputation - per root	50%	50%	1 time per tooth per lifetime
D3470	intentional reimplantation (including necessary splinting)	50%	50%	1 time per tooth per lifetime
D3471	surgical repair of root resorption - anterior	50%	50%	1 time per tooth per lifetime
D3472	surgical repair of root resorption – premolar	50%	50%	1 time per tooth per lifetime
D3473	surgical repair of root resorption – molar	50%	50%	1 time per tooth per lifetime
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	50%	50%	2 times per tooth per lifetime
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	50%	50%	2 times per tooth per lifetime
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	50%	50%	2 times per tooth per lifetime
D3911	intraoffice barrier	50%	50%	Unlimited
D3920	hemisection (including any root removal), not including root canal therapy	50%	50%	1 time per tooth per lifetime
D3999	Unspecified endodontic procedure, by report	50%	50%	Unlimited
Periodontics				
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50%	1 per consecutive 36 months
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%	1 per consecutive 36 months

MediGold PPO Dental Gold				
D4230	anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant	50%	50%	1 per consecutive 36 months
D4231	anatomical crown exposure - one to three teeth or bounded tooth spaces per quadrant	50%	50%	1 per consecutive 36 months
D4240	gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50%	1 per consecutive 36 months
D4241	gingival flap procedure - including root planing -one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%	1 per consecutive 36 months
D4245	apically positioned flap	50%	50%	1 per consecutive 36 months
D4249	clinical crown lengthening - hard tissue	50%	50%	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%	50%	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%	50%	1 per consecutive 36 months
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	50%	50%	1 per consecutive 36 months
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	50%	50%	1 per consecutive 36 months
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	50%	50%	1 per consecutive 36 months
D4266	guided tissue regeneration - resorbable barrier, per site	50%	50%	1 per consecutive 36 months
D4267	guided tissue regeneration - nonresorbable barrier, per site (Includes membrane removal)	50%	50%	1 per consecutive 36 months
D4268	surgical revision procedure, per tooth	50%	50%	1 per consecutive 36 months
D4270	pedicle soft tissue graft procedure	50%	50%	1 per consecutive 36 months

MediGold PPO Dental Gold				
D4273	autogenous connective tissue graft procedure, per first tooth, implant or endentulous tooth position in graft	50%	50%	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%	50%	1 per consecutive 36 months
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth implant	50%	50%	1 per consecutive 36 months
D4276	combined connective tissue and pedicle graft, per tooth	50%	50%	1 per consecutive 36 months
D4277	free soft tissue graft procedure (including recipient and donor surgical sites)first tooth, implant, or edentulous tooth	50%	50%	1 per consecutive 36 months
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	50%	50%	1 per consecutive 36 months
D4283	autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50%	1 per consecutive 36 months
D4285	non-autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50%	1 per consecutive 36 months
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%	50%	1 time per quadrant per consecutive 24 months
D4342	periodontal scaling and root planing - one - three teeth, per quadrant	50%	50%	1 time per quadrant per consecutive 24 months
D4346	scaling in presence of generalized moderate or severe gingival inflammation	50%	50%	2 times per consecutive 12 months.

MediGold PPO Dental Gold				
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	50%	50%	1 per consecutive 36 months
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%	50%	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%	50%	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%	50%	No frequency limitation
D4999	Unspecified periodontal procedure, by report	50%	50%	Unlimited
Dentures				
D5110	complete denture - maxillary	50%	50%	1 per consecutive 60 months
D5120	complete denture - mandibular	50%	50%	1 per consecutive 60 months
D5130	immediate denture - maxillary	50%	50%	1 per consecutive 60 months
D5140	immediate denture - mandibular	50%	50%	1 per consecutive 60 months
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
D5213	maxillary partial denture - cast metal framework with resin denture bases	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
	(including any conventional clasps, rests and			
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	50%	50%	1 per consecutive 60 months
D5221	immediate maxillary partial denture - resin base	50%	50%	1 per consecutive 60 months
D5222	immediate mandibular partial denture - resin base	50%	50%	1 per consecutive 60 months
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases	50%	50%	1 per consecutive 60 months
D5224	immediate mandibular partial denture-cast metal framework with resin denture bases	50%	50%	1 per consecutive 60 months
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	50%	1 per consecutive 60 months
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%	50%	1 per consecutive 60 months
D5283	removable unilateral partial denture – one-piece cast metal (including clasps and teeth), mandibular	50%	50%	1 per consecutive 60 months
D5284	removable unil. part denture – one piece flex. base (incl. retentive/clasping materials, rests, and teeth), per quadrant	50%	50%	1 per consecutive 60 months
D5286	removable unil. part denture – one piece resin (incl. retentive/clasping	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
	materials, rests, and teeth), per quadrant			
D5410	adjust complete denture - maxillary	50%	50%	1 per consecutive 6 months
D5411	adjust complete denture - mandibular	50%	50%	1 per consecutive 6 months
D5421	adjust partial denture - maxillary	50%	50%	1 per consecutive 6 months
D5422	adjust partial denture - mandibular	50%	50%	1 per consecutive 6 months
D5511	repair broken complete denture base, mandibular	50%	50%	1 per consecutive 6 months
D5512	repair broken complete denture base, maxillary	50%	50%	1 per consecutive 6 months
D5520	replace missing or broken teeth - complete denture (each tooth)	50%	50%	1 per consecutive 6 months
D5611	repair resin partial denture base, mandibular	50%	50%	1 per consecutive 6 months
D5612	repair resin partial denture base, maxillary	50%	50%	1 per consecutive 6 months
D5621	repair cast partial framework, mandibular	50%	50%	1 per consecutive 6 months
D5622	repair cast partial framework, maxillary	50%	50%	1 per consecutive 6 months
D5630	repair or replace broken clasp - per tooth	50%	50%	1 per consecutive 6 months
D5640	replace broken teeth - per tooth	50%	50%	1 per consecutive 6 months
D5650	add tooth to existing partial denture	50%	50%	1 per consecutive 6 months
D5660	add clasp to existing partial denture - per tooth	50%	50%	1 per consecutive 6 months
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	50%	50%	1 per consecutive 6 months
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	50%	50%	1 per consecutive 6 months
D5710	rebase complete maxillary denture	50%	50%	1 per consecutive 12 months
D5711	rebase complete mandibular denture	50%	50%	1 per consecutive 12 months
D5720	rebase maxillary partial denture	50%	50%	1 per consecutive 12 months

MediGold PPO Dental Gold				
D5721	rebase mandibular partial denture	50%	50%	1 per consecutive 12 months
D5725	rebase hybrid prosthesis	50%	50%	1 per consecutive 12 months
D5730	reline complete maxillary denture (chairside)	50%	50%	1 per consecutive 12 months
D5731	reline complete mandibular denture (chairside)	50%	50%	1 per consecutive 12 months
D5740	reline maxillary partial denture (chairside)	50%	50%	1 per consecutive 12 months
D5741	reline mandibular partial denture (chairside)	50%	50%	1 per consecutive 12 months
D5750	reline complete maxillary denture (laboratory)	50%	50%	1 per consecutive 12 months
D5751	reline complete mandibular denture (laboratory)	50%	50%	1 per consecutive 12 months
D5760	reline maxillary partial denture (laboratory)	50%	50%	1 per consecutive 12 months
D5761	reline mandibular partial denture (laboratory)	50%	50%	1 per consecutive 12 months
D5765	soft liner for complete or partial removable denture – indirect	50%	50%	1 per consecutive 12 months
D5810	interim complete denture (maxillary)	50%	50%	1 per consecutive 60 months
D5811	interim complete denture (mandibular)	50%	50%	1 per consecutive 60 months
D5820	interim partial denture (maxillary)	50%	50%	1 per consecutive 60 months
D5821	interim partial denture (mandibular)	50%	50%	1 per consecutive 60 months
D5850	tissue conditioning, maxillary	50%	50%	1 per consecutive 12 months
D5851	tissue conditioning, mandibular	50%	50%	1 per consecutive 12 months
D5863	Overdenture-complete maxillary	50%	50%	1 per consecutive 60 months
D5864	Overdenture-partial maxillary	50%	50%	1 per consecutive 60 months
D5865	Overdenture - complete mandibular	50%	50%	1 per consecutive 60 months
D5866	Overdenture-partial mandibular	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
Crowns & Bridges				
D6205	pontic - indirect resin based composite	50%	50%	1 per consecutive 60 months
D6210	pontic - cast high noble metal	50%	50%	1 per consecutive 60 months
D6211	pontic - cast predominantly base metal	50%	50%	1 per consecutive 60 months
D6212	pontic - cast noble metal	50%	50%	1 per consecutive 60 months
D6214	pontic - titanium	50%	50%	1 per consecutive 60 months
D6240	pontic - porcelain fused to high noble metal	50%	50%	1 per consecutive 60 months
D6241	pontic - porcelain fused to predominantly base metal	50%	50%	1 per consecutive 60 months
D6242	pontic - porcelain fused to noble metal	50%	50%	1 per consecutive 60 months
D6243	pontic - porcelain fused to titanium and titanium alloys	50%	50%	1 per consecutive 60 months
D6245	pontic-porcelain/ceramic	50%	50%	1 per consecutive 60 months
D6250	pontic - resin with high noble metal	50%	50%	1 per consecutive 60 months
D6251	pontic - resin with predominantly base metal	50%	50%	1 per consecutive 60 months
D6252	pontic - resin with noble metal	50%	50%	1 per consecutive 60 months
D6253	interim pontic - further treatment or completion of diagnosis necessary prior to final impression	50%	50%	1 per consecutive 60 months
D6545	retainer - cast metal for resin bonded fixed prosthesis	50%	50%	1 per consecutive 60 months
D6548	retainer-porcelain/ceramic for resin bonded fixed prosthesis	50%	50%	1 per consecutive 60 months
D6549	resin retainer - for resin bonded fixed prosthesis	50%	50%	1 per consecutive 60 months
D6600	retainer inlay-porcelain/ceramic, two surfaces	50%	50%	1 per consecutive 60 months
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	50%	50%	1 per consecutive 60 months
D6602	retainer inlay - cast high noble metal, two surfaces	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
D6603	retainer inlay - cast high noble metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6604	retainer inlay - cast predominantly base metal, two surfaces	50%	50%	1 per consecutive 60 months
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6606	retainer inlay - cast noble metal, two surfaces	50%	50%	1 per consecutive 60 months
D6607	retainer inlay - cast noble metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6608	retainer onlay - porcelain/ceramic, two surfaces	50%	50%	1 per consecutive 60 months
D6609	retainer onlay - porcelain/ceramic, three or more surfaces	50%	50%	1 per consecutive 60 months
D6610	retainer onlay - cast high noble metal, two surfaces	50%	50%	1 per consecutive 60 months
D6611	retainer onlay - cast high noble metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6612	retainer onlay - cast predominantly base metal, two surfaces	50%	50%	1 per consecutive 60 months
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6614	retainer onlay - cast noble metal, two surfaces	50%	50%	1 per consecutive 60 months
D6615	retainer onlay - cast noble metal, three or more surfaces	50%	50%	1 per consecutive 60 months
D6624	retainer inlay - titanium	50%	50%	1 per consecutive 60 months
D6634	retainer onlay - titanium	50%	50%	1 per consecutive 60 months
D6710	retainer crown - indirect resin based composite (not to be used as a temporary or provisional crown)	50%	50%	1 per consecutive 60 months
D6720	retainer crown - resin with high noble metal	50%	50%	1 per consecutive 60 months
D6721	retainer crown - resin with predominantly base metal	50%	50%	1 per consecutive 60 months
D6722	retainer crown - resin with noble metal	50%	50%	1 per consecutive 60 months
D6740	retainer crown-porcelain/ceramic	50%	50%	1 per consecutive 60 months

MediGold PPO Dental Gold				
D6750	retainer crown - porcelain fused to high noble metal	50%	50%	1 per consecutive 60 months
D6751	retainer crown - porcelain fused to predominantly base metal	50%	50%	1 per consecutive 60 months
D6752	retainer crown - porcelain fused to noble metal	50%	50%	1 per consecutive 60 months
D6753	retainer crown - porcelain fused to titanium and titanium alloys	50%	50%	1 per consecutive 60 months
D6780	retainer crown - 3/4 cast high noble metal	50%	50%	1 per consecutive 60 months
D6781	retainer crown-3/4 cast predominately based metal	50%	50%	1 per consecutive 60 months
D6782	retainer crown-3/4 cast noble metal	50%	50%	1 per consecutive 60 months
D6783	retainer crown-3/4 porcelain/ceramic	50%	50%	1 per consecutive 60 months
D6784	retainer crown 3/4 - titanium and titanium alloys	50%	50%	1 per consecutive 60 months
D6790	retainer crown - full cast high noble metal	50%	50%	1 per consecutive 60 months
D6791	retainer crown - full cast predominantly base metal	50%	50%	1 per consecutive 60 months
D6792	retainer crown - full cast noble metal	50%	50%	1 per consecutive 60 months
D6793	interim retainer crown-further treatment or completion of diagnosis necessary prior to final impression	50%	50%	1 per consecutive 60 months
D6794	retainer crown - titanium	50%	50%	1 per consecutive 60 months
D6930	recement or re-bond fixed partial denture	0%	0%	1 per consecutive 6 months
D6980	fixed partial denture repair, necessitated by restorative material failure	50%	50%	1 per consecutive 6 months
Oral & Maxillofacial Surgery				
D7111	extraction, coronal remnants - primary tooth	50%	50%	1 time per tooth per lifetime
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%	50%	1 time per tooth per lifetime
D7210	extraction, erupted tooth req removal of bone,sectioning of tooth and	50%	50%	1 time per tooth per lifetime

MediGold PPO Dental Gold				
	including elevation of mucoperiosteal flap			
D7220	removal of impacted tooth - soft tissue	50%	50%	1 time per tooth per lifetime
D7230	removal of impacted tooth - partially bony	50%	50%	1 time per tooth per lifetime
D7240	removal of impacted tooth - completely bony	50%	50%	1 time per tooth per lifetime
D7241	removal of impacted tooth - completely bony, with unusual surgical	50%	50%	1 time per tooth per lifetime
D7250	removal of residual tooth roots (cutting procedure)	50%	50%	1 time per tooth per lifetime
D7251	Coronectomy – intentional partial tooth removal	50%	50%	Unlimited
D7260	oroantral fistula closure	50%	50%	1 per site per visit
D7261	primary closure of a sinus perforation	50%	50%	1 time per lifetime
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%	1 time per site per lifetime
D7272	tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	50%	50%	1 time per tooth per lifetime
D7280	exposure of an unerupted tooth	50%	50%	1 time per tooth per lifetime
D7282	mobilization of erupted or malpositioned tooth to aid eruption	50%	50%	1 time per tooth per lifetime
D7283	placement of device to facilitate eruption of impacted tooth	50%	50%	1 time per tooth per lifetime
D7285	incisional biopsy of oral tissue - hard (bone, tooth)	50%	50%	1 biopsy per site per visit
D7286	incisional biopsy of oral tissue - soft (all others)	50%	50%	1 biopsy per site per visit
D7287	exfolliative cytological sample collection	50%	50%	1 biopsy per site per visit
D7288	brush biopsy - transepithelial sample collection	50%	50%	1 biopsy per site per visit
D7290	Surgical repositioning of teeth	50%	50%	Unlimited
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	50%	50%	1 time per tooth per lifetime

MediGold PPO Dental Gold				
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	50%	No frequency limitation
D7311	alveoplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	50%	50%	No frequency limitation
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	50%	No frequency limitation
D7321	alveoplasty not in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	50%	50%	No frequency limitation
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	50%	50%	1 per consecutive 60 months
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment	50%	50%	1 per consecutive 60 months
D7410	excision of benign lesion up to 1.25 cm	50%	50%	1 per site per visit
D7411	excision of benign lesion greater than 1.25 cm	50%	50%	1 per site per visit
D7412	excision of benign lesion, complicated	50%	50%	1 per site per visit
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%	50%	1 per site per visit
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%	50%	1 per site per visit
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%	50%	1 per site per visit
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%	50%	1 per site per visit
D7472	removal of torus palatinus	50%	50%	1 per site per visit
D7473	removal of torus mandibularis	50%	50%	1 per site per visit
D7510	incision and drainage of abscess - intraoral soft tissue	50%	50%	1 per site per visit
D7511	incision and drainage of abscess - intraoral soft tissue - complicated	50%	50%	1 per site per visit

MediGold PPO Dental Gold				
	(includes drainage of multiple fascial spaces)			
D7520	incision and drainage of abscess - extraoral soft tissue	50%	50%	1 per site per visit
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	50%	1 per site per visit
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	50%	50%	1 per site per visit
D7540	removal of reaction-producing foreign bodies - musculoskeletal system	50%	50%	1 per site per visit
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	50%	50%	1 per site per visit
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	50%	50%	1 per site per visit
D7881	occlusal orthotic device adjustment	50%	50%	1 per consecutive 6 months
D7910	Suture of recent small wounds up to 5 cm	50%	50%	Unlimited
D7953	Bone replacement graft for ridge preservation - per site	50%	50%	1 per site per lifetime
D7961	buccal / labial frenectomy (frenulectomy)	50%	50%	No frequency limitation
D7962	lingual frenectomy (frenulectomy)	50%	50%	No frequency limitation
D7963	frenuloplasty	50%	50%	No frequency limitation
D7970	excision of hyperplastic tissue - per arch	50%	50%	1 per site per consecutive 36 months
D7971	excision of pericoronal gingiva	50%	50%	1 per site per consecutive 36 months
D7972	surgical reduction of fibrous tuberosity	50%	50%	No frequency limitation
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	50%	50%	1 per appliance per lifetime
D7999	Unspecified oral surgery procedure, by report	50%	50%	Unlimited

MediGold PPO Dental Gold				
Adjunctive General Services				
D9110	palliative (emergency) treatment of dental pain - minor procedure	0%	0%	No frequency limitation
D9120	fixed partial denture sectioning	0%	0%	1 per consecutive 60 months
D9210	local anesthesia not in conjunction with operative or surgical procedures	0%	0%	No frequency limitation
D9215	local anesthesia in conjunction with operative or surgical procedures	0%	0%	No frequency limitation
D9219	evaluation for deep sedation or general anesthesia	0%	0%	4 times per consecutive 12 months
D9222	deep sedation/general anesthesia - first 15 minutes	0%	0%	No frequency limitation
D9223	deep sedation/general anesthesia-each subsequent 15 minute increment	0%	0%	No frequency limitation
D9230	inhalation of nitrous oxide/anxiolysis analgesia	0%	0%	No frequency limitation
D9239	intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	0%	0%	No frequency limitation
D9243	intravenous moderate (conscious) sedation/analgesia-each subsequent 15 minute increment	0%	0%	No frequency limitation
D9248	non-intravenous conscious sedation. This includes non-iv minimal and moderate sedation	0%	0%	No frequency limitation
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	0%	0%	4 per consecutive 12 months
D9610	therapeutic parenteral drug, single administration	0%	0%	1 per visit
D9612	therapeutic parenteral drugs, two or more administrations, different medications	0%	0%	1 per visit
D9630	drugs orbmedicaments, dispensed in the office for home use	0%	0%	1 per visit
D9910	application of desensitizing medicament	0%	0%	No frequency limitation
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	0%	0%	No frequency limitation

MediGold PPO Dental Gold				
D9912	pre-visit patient screening	0%	0%	2 per calendar year
D9942	repair and/or reline of occlusal guards	0%	0%	1 per consecutive 12 months
D9943	occlusal adjustment	0%	0%	1 per consecutive 6 months
D9944	occlusal guard - hard appliance, full arch	0%	0%	1 per site per consecutive 36 months
D9945	occlusal guard - soft appliance, full arch	0%	0%	1 per site per consecutive 36 months
D9946	occlusal guard - hard appliance, partial arch	0%	0%	1 per site per consecutive 36 months
D9947	custom sleep apnea appliance fabrication and placement	0%	0%	1 per site per consecutive 36 months
D9948	adjustment of custom sleep apnea appliance	0%	0%	1 per consecutive 6 months
D9949	repair of custom sleep apnea appliance	0%	0%	1 per consecutive 12 months
D9950	occlusion analysis - mounted case	0%	0%	1 per consecutive 60 months
D9951	occlusal adjustment - limited	0%	0%	No frequency limitation
D9952	occlusal adjustment - complete	0%	0%	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** per month. The premium for the Dental Gold plan is **$43** per month. 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 10. 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 in our plan 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 $1,500 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 9, 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.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Dentures, crowns and bridges.	✓	
Diagnostic services, including X-rays, performed in a chiropractor's office.	✓	
Driving evaluations or driving assessments.	✓	
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.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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		✓
Homemaker services including basic household assistance, such as 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.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.		✓
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	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services and items required by a newborn on the basis of the mother's membership in the plan.	✓	
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 not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.	✓	
Scheduled or routine service outside the U.S.	✓	
Surgical treatment for morbid obesity.		✓ Covered when medically necessary or when covered under Original Medicare.
Travel immunizations.	✓	
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:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy* or through the plan's mail-order service).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are on the plan's Drug List.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (MediGold.com/Find-A-Provider), and/or call Member Services.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Services or use the *Provider/Pharmacy Directory*. You can also find information on our website at MediGold.com/Find-A-Provider.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Note: Generally, nursing care for home infusion is not covered unless you are homebound.
    - The following conditions apply for home infusion therapy:
        - Your doctor has written a prescription for a home infusion drug.
        - Your need meets the MediGold criteria for coverage.
        - Your prescription drug must be on the plan formulary, or a formulary exception has been granted for the prescription drug.
        - Your prescription drug is not otherwise covered under our plan's medical benefit.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact CVS Caremark Customer Service. The number can be found in Chapter 2, Section 1 of this booklet.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider/Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked with an NM in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply.**

To get order forms and information about filling your prescriptions by mail, contact CVS Caremark, our pharmacy benefit manager, at 1-800-785-5714, option 2 (TTY 711) or by visiting www.caremark.com.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days from the time that the mail order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact CVS Caremark at 1-866-785-5714, option 2 (TTY 711). If CVS Caremark expects the order to be delayed, it will contact you and help you decide whether to wait for the medication, cancel the mail order or fill the prescription at a local retail or chain pharmacy. Our Member Services Department will work with you to obtain the drug(s) at a network retail pharmacy if necessary to ensure you do not go without your medication. You will still have a copay at the retail pharmacy when such arrangements are made.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by continuing to have your doctor send us your prescriptions. No special request is needed. You may contact CVS Caremark to restart automatic deliveries if you previously stopped automatic deliveries.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling CVS Caremark at 1-866-785-5714, option 2 (TTY 711).

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact CVS Caremark at 1-866-785-5714, option 2 (TTY 711).

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Services** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- This plan will cover up to a 30-day supply of prescriptions filled at an out-of-network pharmacy if the prescription is related to care for a medical emergency or urgently needed care at such times when a network pharmacy is not reasonably accessible.
- This plan will allow up to a 30-day supply of prescriptions filled at an out-of-network pharmacy when you travel or are away from the plan's service area and a network pharmacy is not reasonably accessible in the U.S.
- This plan may also cover up to a 30-day supply of prescriptions filled at an out-of-network pharmacy when you are unable to obtain the needed medication in a timely manner within our network; for instance, when a 24-hour service is needed and not reasonably accessible within our network at the time.
- This plan may also cover up to a 30-day supply of prescriptions at an out-of-network pharmacy if you are trying to fill a covered prescription that is not regularly stocked at an eligible network retail pharmacy (such as specialty pharmaceuticals).

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs and biosimilars

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the drug list, when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biological alternatives available for many brand name drugs and some biological products.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

Section 3.2 There are five "cost sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of five cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug:

- Tier 1: Preferred Generic – is the lowest tier and includes preferred generic drugs and may include some brand drugs.
- Tier 2: Generic – includes generic drugs and may include some brand drugs.
- Tier 3: Preferred Brand – includes preferred brand drugs and non-preferred generic drugs.
- Tier 4: Non-Preferred Drug – includes non-preferred brand drugs and generic drugs.
- Tier 5: Specialty Tier – is the highest tier and includes high-cost brand and generic drugs.

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have four ways to find out:

1. Check the most recent Drug List.
2. Visit the plan's website (MediGold.com/Formulary). The Drug List on the website is always the most current.
3. In addition, you can get an estimated cost of your drug by using the Find and Price a Drug tool found on the plan's website at MediGold.com/Tools-and-Resources/Drug-Benefits/Find-A-Drug.
4. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you *OR* has written 'No substitutions' on your prescription for a brand name drug *OR* has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you,

then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.

- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first ***90 days*** of your membership in the plan**.**
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than *90 days* and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those members who have been in the plan for more than 90 days and experience a level of care change (from one treatment setting to another):**

  You may have an unplanned transition, such as a move from a hospital to a long-term care facility. If this happens and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover up to a temporary 30-day supply (or 31-day supply if you are a resident of a long-term care facility) when you go to a network pharmacy. This gives you time to talk to your doctor about other treatment options. After your first 30-day supply in such situations, you are required to use the plan's formulary exception process.

For questions about a temporary supply, call Member Services.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost sharing tier you think is too high?

If your drug is in a cost sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

For drugs in Tier 2, Tier 3, and Tier 4 you and your provider can ask the plan to make an exception in the cost sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Specialty Tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost sharing tier.**
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or change the cost sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next

year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.

- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. MediGold covers sildenafil citrate (generic Viagra) in 25mg, 50mg and 100mg tablets; Vardenafil ODT (generic Levitra/Staxyn) in 5mg, 10mg, and 20mg; and tadalafil (generic Cialis) in 2.5mg, 5mg, 10mg and 20mg with a prescription for males only. Eligible members may receive four (4) tablets across all strengths per 30 days at retail pharmacy locations only (not available at mail order). A Tier 2 copay will apply. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

In addition, if you are **receiving "Extra Help" to** pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider/Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable."

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications.

You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

CHAPTER 6:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider."

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by our plan if you have purchased supplemental drug coverage.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost sharing," and there are three ways the following represent the ways you may be asked to pay.

- The **"deductible"** is the amount you pay for drugs before our plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $7,400 in out-of-pocket costs within the calendar year, you will move from the initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.

- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Services.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D EOB report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $7,400, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it's on, even if you haven't paid your deductible.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you

when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a *Part D Explanation of Benefits* ("Part D EOB"). The Part D EOB includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs cost, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
    - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Your Part D EOBs are available either on paper by mail or electronically online. To enroll for electronic copies of EOBs, sign into your Caremark.com account and select the electronic option or contact CVS Customer Care and request digital EOB option at 1-866-785-5714. TTY users should call 711. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs

The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of $150 on Tier 3, Tier 4 and Tier 5 drugs. **You must pay the full cost of your Tier 3, Tier 4 and Tier 5 drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible. The **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $150 for your Tier 3, Tier 4 and Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost sharing tiers

Every drug on the plan's Drug List is in one of five cost sharing tiers. In general, the higher the cost sharing tier number, the higher your cost for the drug:

- Cost Sharing Tier 1: Preferred Generic – the lowest tier and includes preferred generic drugs and may include some brand drugs.
- Cost Sharing Tier 2: Generic – includes generic drugs and may include some brand drugs.

- Cost Sharing Tier 3: Preferred Brand – includes preferred brand drugs and non-preferred generic drugs.
- Cost Sharing Tier 4: Non-Preferred Drug – includes non-preferred brand and generic drugs.
- Cost Sharing Tier 5: Specialty Tier – the highest tier and includes high-cost brand and generic drugs.

To find out which cost sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Provider/Pharmacy Directory.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay	$0 copay*
Cost Sharing Tier 2 (Generic)	$5 copay	$0 copay	$5 copay	$5 copay*
Cost Sharing Tier 3 (Preferred Brand)	$47 copay $35 copay for insulins	$47 copay $35 copay for insulins	$47 copay $35 copay for insulins	$47 copay* $35 copay for insulins
Cost Sharing Tier 4 (Non-Preferred Drug)	$100 copay	$100 copay	$100 copay	$100 copay*
Cost Sharing Tier 5 (Specialty Tier)	30% coinsurance $35 copay for insulins	30% coinsurance $35 copay for insulins	30% coinsurance $35 copay for insulins	30% coinsurance* $35 copay for insulins

*You may have to pay more than your usual cost sharing amount if you get your drugs at an out-of-network pharmacy.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor

to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Cost Sharing Tier 1 (Preferred Generic)	$0 copay	$0 copay
Cost Sharing Tier 2 (Generic)	$15 copay	$0 copay
Cost Sharing Tier 3 (Preferred Brand)	$141 copay $105 copay for insulins	$94 copay $70 copay for insulins
Cost Sharing Tier 4 (Non-Preferred Drug)	$300 copay	$200 copay
Cost Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,660

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$4,660 limit for the Initial Coverage Stage**.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out of pocket costs.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $4,660 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Additionally, the Plan will continue to provide coverage for generic drugs in Tier 1 (Preferred Generic) during the Coverage Gap stage at a Tier 1 copay. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $7,400, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs. You will pay:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
    - *either* – coinsurance of 5% of the cost of the drug
    - *–or* – $4.15 for a generic drug or a drug that is treated like a generic and $10.35 for all other drugs.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered medical benefits. (See the *Medical Benefits Chart (what is covered and what you pay)* in Chapter 4).
    - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist may give the vaccine in the pharmacy or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what Drug Stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give vaccines.)

- You will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.

- You will be reimbursed the amount you paid less your normal coinsurance or copay for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

CHAPTER 7:

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

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

Sometimes when you get medical care or a prescription drug, 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 or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

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

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

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

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

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

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

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

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs 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.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out of network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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 9 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, item, or within 3 years for Part D drugs.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website at MediGold.com/For-Members/Resources/Forms or call Member Services and ask for the form.

Mail your request for payment **of a medical claim** 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

Mail your request for **payment of a Part D prescription drug claim** together with any bills or paid receipts to us at this address:

Medicare Part D Paper Claims
P.O. Box 52066
Phoenix, AZ 85072-2066

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 or drug 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 or drug 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 or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug 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 or drug, 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 9 of this document.

CHAPTER 8:
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 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, 614-546-3181 (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 and drugs

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

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, 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 including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; 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 health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that 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 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 No Premium Choice (PPO), you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies 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. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, 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 9 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 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.
    - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, 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 or Part D prescription drugs.
- **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 pay your plan premiums.

You must continue to pay your Medicare Part B premiums to remain a member of the plan.

For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.

If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **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 9:

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" or "coverage determination" or "at-risk 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 10** 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 and prescription drugs, 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 or drugs. 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 or drug 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. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter). 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 9 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 Member Services**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services 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.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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 other person to be your representative, call Member Services 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 four 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: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** 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 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services. 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 7 and 8 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 10 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 10 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 10 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 9 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 7 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 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.

- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 6.2**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost sharing amount that applies to drugs in Tier 5. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on our Drug List is in one of five cost sharing tiers. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.
    - If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You cannot ask us to change the cost sharing tier for any drug in Tier 5- Specialty Drug Tier.
    - If we approve your tiering exception request and there is more than one lower cost sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

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

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

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber'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 or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information. You can submit a secure electronic request online by using the Request for Medicare Coverage Determination Form found at MediGold.com/Members/Resources/Forms. If you are unable to complete the form, a prescriber or authorized representative can do so on your behalf. On the form, simply fill in the required information and click submit. Your request will be sent securely and directly to CVS Caremark. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the "supporting statement,"** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a "fast coverage decision"

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **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. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.

- For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **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. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **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. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."** A "fast appeal" is also called an **"expedited redetermination."**

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

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a "fast appeal."

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You can submit a secure electronic request online** by using the Request for Medicare Coverage Redetermination Form found at MediGold.com/For-Members/Resources/Forms. If you are unable to complete the form, a prescriber or authorized representative can do so on your behalf. On the form, simply fill in the required information and click submit. Your request will be sent securely and directly to CVS Caremark.
- **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 in your appeal and add more information.** 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 we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

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.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must 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 a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar days** after we receive your request.

- **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. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- 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.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast" appeal

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a "fast appeal," the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for "standard" appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For "standard appeals":

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no **to part or all of** your appeal**,** it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: 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 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 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 7.1 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 Member Services 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:
    - 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 Member Services 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 7.2 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 Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

The **Quality Improvement Organization** is a group of doctors and other health care professionals 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 7.4.

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 must use network providers to get your medical care and services. by calling Member Services 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 7.3 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.
- 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 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 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 10 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *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 8.2 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 <u>not</u> mean you agree** with the plan's decision to stop care.

Section 8.3 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 Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

The **Quality Improvement Organization** is a group of doctors and other health care experts 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 8.5.

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 8.4 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 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.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug 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 value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal **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 answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, 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 or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

Section 10.1 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, pharmacists, 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, or getting a prescription.
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 or drugs 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 10.2 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 10.3 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 Grievance 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.

For a grievance issue related to Part D prescription drugs, mail to:

CVS Caremark Medicare Part D Grievance Department
P.O. Box 30016
Pittsburgh, PA 15222-0330

- **Upon receipt of your grievance letter**, CVS Caremark will thoroughly review, research and respond to your letter in a timely manner and provide written response to your grievance within 30 days of receipt of your letter. You may also request to have CVS Caremark 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 time frame needed to make a coverage determination or a decision regarding reconsideration request.
  - If you have a complaint about MediGold refusing to grant a request for an expedited coverage 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 10.4 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 10.5 You can also tell Medicare about your complaint

You can submit a complaint about *MediGold Mount Carmel No Premium Choice* 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 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MediGold Mount Carmel No Premium Choice (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where 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 prescription drugs 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.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
- **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 No Premium Choice (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

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

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

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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 No Premium Choice (PPO) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from MediGold Mount Carmel No Premium Choice (PPO) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• 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 No Premium Choice (PPO) when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **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 No Premium Choice (PPO) 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 No Premium Choice (PPO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.

- If you move or take a long trip, call 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 lie or withhold information about other insurance you have that provides prescription drug coverage.
- 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.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

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 No Premium Choice (PPO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, 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 11:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). 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﷿
េដើម្បីេធ﷿ើេយ﷿នឹងសណ្ឋ ិ﷿មួយ
ែដលអ﷿ក﷿ច﷿នអំពីគ្រ﷿ងសុខ﷿ព ឬឱសថរបស់េយើង។
េដើម្បីទទួល﷿នអ﷿កបក្រៃប សូ មទូរសព﷿មកេយើងខ﷿ ﷿ំ﷿មយ:េលខ 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 No Premium Choice (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 12:
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 prescription drugs or payment for services or drugs 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 No Premium Choice (PPO), you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that 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.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,400 in covered drugs during the covered year.

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 or prescription drugs after you pay any deductibles.

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

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

Cost Sharing Tier – Every drug on the list of covered drugs is in one of five cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care,

provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost sharing rate – A "daily cost sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost sharing rate" is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another

drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, 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."

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,660.

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

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

you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

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

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

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

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

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 Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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 such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

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 or drugs 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.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

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 or certain drugs. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior

authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

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.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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 plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, 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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Columbus, Ohio 43219
MediGold.com

	MediGold Mount Carmel No Premium Choice (PPO) 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	**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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