

2026 Evidence of Coverage for Trinity Health Plan of Michigan Glory No RX (HMO)



January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of Trinity Health Plan of Michigan Glory No RX (HMO)

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

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

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

For questions about this document, call Member Services at 1-800-240-3851. (TTY users call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Trinity Health Plan of Michigan Glory No RX (HMO), is offered by Trinity Health Plan Of Michigan Inc (Trinity Health Plan Of Michigan Inc). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Trinity Health Plan of Michigan (Trinity Health Plan Of Michigan Inc). When it says “plan” or “our plan,” it means Trinity Health Plan of Michigan Glory No RX (HMO).)

This information is available in large print or audio.

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

Our provider network can change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1:

Get started as a member

SECTION 1 **You're a member of Trinity Health Plan of Michigan Glory No RX (HMO)**

Section 1.1	You're enrolled in Trinity Health Plan of Michigan Glory No RX (HMO), which is a Medicare HMO
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You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Trinity Health Plan of Michigan Glory No RX (HMO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Trinity Health Plan of Michigan Glory No RX (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Trinity Health Plan of Michigan Glory No RX (HMO) doesn't include Part D drug coverage.

Section 1.2	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with you about how Trinity Health Plan of Michigan Glory No RX (HMO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Trinity Health Plan of Michigan Glory No RX (HMO) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Trinity Health Plan of Michigan Glory No RX (HMO) after December 31, 2026. We can also choose to stop offering our plan, or to offer it in your service area after December 31, 2026.

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Medicare (the Centers for Medicare & Medicaid Services) must approve Trinity Health Plan of Michigan Glory No RX (HMO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

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

Section 2.2 Plan service area for Trinity Health Plan of Michigan Glory No RX (HMO)

Trinity Health Plan of Michigan Glory No RX (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Michigan: Clinton, Eaton, Genesee, Gratiot, Ingham, Ionia, Kent, Lake, Lapeer, Livingston, Macomb, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Sanilac, Tuscola, Washtenaw and Wayne.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-800-240-3851 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify

Chapter 1 Get started as a member

Trinity Health Plan of Michigan Glory No RX (HMO) if you're not eligible to stay a member of our plan on this basis. Trinity Health Plan of Michigan Glory No RX (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership material

Section 3.1 Our plan membership card

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



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Trinity Health Plan of Michigan Glory No RX (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-800-240-3851 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* at www.thpmedicare.org/michigan/find-a-provider lists our current network providers and durable medical equipment suppliers. **Network providers** are the

Chapter 1 Get started as a member

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Trinity Health Plan of Michigan Glory No RX (HMO) authorizes use of out-of-network providers.

We included a copy of our *Durable Medical Equipment Supplier Directory* in the envelope with this document. The most recent list of providers and suppliers is available on our website at www.thpmedicare.org/michigan/find-a-provider.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-240-3851 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	\$0
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	\$6,500
Primary care office visits	\$0 copay per visit
Specialist office visits	\$30 copay per visit
Inpatient hospital stays	\$295 copay per day for days 1-7; \$0 copay per day for days 8-90

Chapter 1 Get started as a member

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)

Section 4.1	Plan premium
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You don't pay a separate monthly plan premium for Trinity Health Plan of Michigan Glory No RX (HMO).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

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

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

As a member of this plan, Trinity Health Plan of Michigan Glory No RX (HMO) will reduce your monthly Medicare Part B premium by \$100. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction can be credited to your Social Security check or credited on your Medicare Part B premium statement.

Section 4.3	Optional Supplemental Benefit Premium
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If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details. Your premium for the optional supplemental benefits is \$14 for the Silver Premium Supplemental Plan or \$39 for the Gold Premium Supplemental Plan.

SECTION 5 More information about your monthly plan premium

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

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

SECTION 6 Keep our plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Member Services at 1-800-240-3851 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage that we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-240-3851 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)

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- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 **Trinity Health Plan of Michigan Glory No RX (HMO) contacts**

For help with claims, billing, or member card questions, call or write to Trinity Health Plan of Michigan Glory No RX (HMO) Member Services at 1-800-240-3851 (TTY users call 711). We'll be happy to help you.

Member Services – Contact Information

Call	1-800-240-3851 Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week Member Services also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week
Fax	1-833-256-2871
Write	Trinity Health Plan of Michigan Attn: Member Services 3100 Easton Square Place Suite 300 Columbus, OH 43219
Website	www.thpmedicare.org/michigan/

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

Coverage Decisions and Appeals for Medical Care – Contact Information

Call	1-800-240-3870 (coverage decisions) 1-800-240-3851 (appeals) Calls to these numbers are free. Monday – Friday, 8 a.m. to 4:30 p.m. with weekend coverage for CMS-defined expedited requests (coverage decisions) 8 a.m. to 8 p.m., 7 days a week (appeals)
TTY	711 (coverage decisions) 711 (appeals) Calls to this number are free. Monday – Friday, 8 a.m. to 4:30 p.m. with weekend coverage for CMS-defined expedited requests (coverage decisions) 8 a.m. to 8 p.m., 7 days a week (appeals)
Fax	1-833-263-4869 (coverage decisions) 1-833-802-2495 (appeals)
Write	Coverage decisions: Trinity Health Plan of Michigan Attn: Health Services (Coverage Decisions) 3100 Easton Square Place Suite 300 Columbus, OH 43219 Appeals: Trinity Health Plan of Michigan Attn: Appeals and Grievances Department (Appeals) 3100 Easton Square Place Suite 300 Columbus, OH 43219

Coverage Decisions and Appeals for Medical Care – Contact Information

Website	www.thpmedicare.org/michigan/for-members/appeals-and-grievances (coverage decisions) www.thpmedicare.org/michigan/for-members/appeals-and-grievances (appeals)
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Coverage Decisions and Appeals for Medicare Part B drugs - Contact Information

Call	1-800-932-7013 (coverage decisions) Monday – Friday 9 a.m.– 7 p.m. EST Weekend coverage on Saturday & Sunday 8 a.m. – 4:30 p.m. EST (coverage decisions) 1-800-240-3851 (appeals) 8 am to 8pm, 7 days a week (appeals)
TTY	711 (coverage decisions) Monday – Friday 9 a.m.– 7 p.m. EST with weekend coverage on Saturday & Sunday 8 a.m. – 4:30 p.m. EST (coverage decisions) 711 (appeals) 8 am to 8pm, 7 days a week (appeals) Calls to this number are free.
Fax	1-844-306-1163 (coverage decisions) 1-833-802-2495 (appeals)

Coverage Decisions and Appeals for Medicare Part B drugs - Contact Information

Write	Coverage decisions: CVS Caremark Medicare Part B Department Attn: Part B NLX Team P.O. Box 52000 MC 109 Phoenix, AZ 85072-2000 Appeals: Trinity Health Plan of Michigan Attn: Appeals and Grievances Department (Appeals) 3100 Easton Square Place Suite 300 Columbus, OH 43219
Website	www.thpmedicare.org/michigan/for-members/appeals-and-grievances (coverage decisions) www.thpmedicare.org/michigan/for-members/appeals-and-grievances (appeals)

How to make a complaint about your medical care

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

Complaints about Medical Care – Contact Information

Call	1-800-240-3851 Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week
Fax	1-833-802-2495

Complaints about Medical Care – Contact Information

Write	Trinity Health Plan of Michigan Attn: Appeals and Grievances Coordinator 3100 Easton Square Place Suite 300 Columbus, OH 43219
Medicare Website	To submit complaint about Trinity Health Plan of Michigan Glory No RX (HMO) directly to Medicare at Medicare.gov.

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

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

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

Payment Requests – Contact Information

Call	1-800-240-3851 8 a.m. to 8 p.m., 7 days a week Calls to this number are free.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week
Fax	1-833-256-2871
Write	Trinity Health Plan of Michigan Attn: Member Services 3100 Easton Square Place Suite 300 Columbus, OH 43219
Website	www.thpmedicare.org/michigan/for-members/billing-and-financial-assistance

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information

Call	1-800-MEDICARE, 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.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Medicare – Contact Information

Website

www.Medicare.gov

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Trinity Health Plan of Michigan Glory No RX (HMO):

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Michigan, the SHIP is called Michigan Medicare Assistance Program (MMAAP, Inc.).

Michigan Medicare Assistance Program (MMAAP, Inc.) 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.

Michigan Medicare Assistance Program (MMAAP, Inc.) 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. Michigan Medicare Assistance Program (MMAAP, Inc.) counselors can also help you with Medicare questions or problems and

Chapter 2 Phone numbers and resources

help you understand your Medicare plan choices and answer questions about switching plans.

Michigan Medicare Assistance Program (MMAP, Inc.) – Contact Information

Call	1-800-803-7174
Write	MMAP, Inc. 6015 W. Saint Joseph Highway Suite 103 Lansing, MI 48917 MDHHS-MIOPTIONS@Michigan.gov
Website	https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Commence Health in any of these situations:

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

Commence Health (Michigan's Quality Improvement Organization) – Contact Information

Call	1-888-524-9900 Monday – Friday: 9 a.m. to 5 p.m. (local time) Saturday, Sunday and Holidays: 10 a.m. to 4 p.m. (local time) 24 hour voicemail service is available
TTY	711
Write	BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450
Website	www.livantaqio.cms.gov/en

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security – Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact Michigan Department of Health and Human Services.

Michigan Department of Health and Human Services (Michigan's Medicaid program) – Contact Information

Call	1-517-241-3740 Available Monday – Friday, 8 a.m. to 5 p.m.
Write	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, MI 48909
Website	www.michigan.gov/medicaid

SECTION 7 Railroad Retirement Board (RRB)

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

Chapter 2 Phone numbers and resources

Railroad Retirement Board (RRB) – Contact Information

Call	1-877-772-5772 Calls to this number are free. Press 0, to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press “1”, to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number aren’t free.
WEBSITE	https://RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-800-240-3851 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services
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- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

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

As a Medicare health plan, Trinity Health Plan of Michigan Glory No RX (HMO) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

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Trinity Health Plan of Michigan Glory No RX (HMO) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 of this chapter for more information).
 - In some situations, our plan must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.2.
 - You don't need referrals from your PCP for emergency care or urgently needed services.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you have to pay the provider in full for services you get. *Here are 3 exceptions:*
 - Our plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services are, go to Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. However, you or your provider must get prior authorization (approval) by our plan for the out-of-network care before seeking non-emergency or non-urgent care out-of-network. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.3 in this chapter.
 - Our plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-

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network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network the cost sharing for the dialysis may be higher.

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

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

A 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're 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 Trinity Health Plan of Michigan, you DON'T need a referral from him or her before seeking care from your other in-network providers. You can 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 get prior authorization for supplies and services if prior authorization is needed.

How to choose a PCP

You can select your PCP by using the Trinity Health Plan of Michigan *Provider Directory* or by getting help from Member Services. You can also access a list of PCPs online at www.thpmedicare.org/michigan/find-a-provider.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP.

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

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

You don't need a referral from your PCP to seek covered care from network providers, including specialists. However, there are specific services that require prior authorization regardless of the provider you use. For a list of services that require prior authorization, refer to Chapter 4, Section 2.

Network providers will request prior authorization on your behalf when needed. You and out-of-network providers can also request prior authorization when needed (see *How to contact us when you're asking for a coverage decision about your medical care* in Chapter 2). When Trinity Health Plan of Michigan 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 can apply. If a prior authorization request is denied, you or the requesting provider can ask for an appeal (see Chapter 7, 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 Trinity Health Plan of Michigan ID card.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.

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- If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior Authorization is needed for services from an out-of-network provider.
- If you find out your doctor or specialist is leaving our plan, call Member Services at 1-800-240-3851 (TTY users call 711) so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7)

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

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

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

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

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

Your doctor can call 1-800-240-3870 to get instructions on our plan's prior authorization process, related form(s) and handling. When requests are received, our plan will promptly make a determination regarding the request. Our plan will then alert the requestor of its determination (approved or denied). Trinity Health Plan of Michigan follows CMS timeframes, which allows us up to 7 days to render a decision, but if all necessary information is submitted by your provider, we'll respond promptly. In some cases, you or our plan can ask for an additional 7 days to further research facts related to the request or to get more information, when doing so can benefit the member. If we decide to take the extra days, we'll tell you in writing. If your medical condition or situation requires expedited handling of a request, you or your doctor can request an expedited review. For details related to what qualifies for an expedited request, please refer to Chapter 7, Section 5.2 of this document. If an expedited review is warranted, determinations related to your request will be made within 72 hours. If your request is approved, we'll notify the requesting doctor of the approval and give details as to what services were approved and where they can be performed. If your prior authorization request is denied, you'll be sent a letter stating why the request was denied and be provided your rights for filing an appeal as noted in Chapter 7, Section 5.

If you have questions regarding prior authorization, its processes or wish to make a request yourself, please call Member Services at 1-800-240-3851 (TTY users call 711).

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

Section 3.1 Get care if you have a medical emergency
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A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval

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or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, as well as worldwide emergency and urgent care coverage, and from any provider with an appropriate state license even if they are not part of our network.

Covered services in a medical emergency

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

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

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

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2	Get care when you have an urgent need for services
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A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and

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injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

If you have an urgent need for services as described above and find that participating providers aren't reasonably accessible, you can access urgently needed services from any Medicare-approved urgent care center. Urgent care centers aren't generally associated with a hospital's emergency room (although they can 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 worldwide emergency and urgent care services worldwide.

Section 3.3	Get care during a disaster
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If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit www.medicare.gov/what-medicare-covers/getting-care-and-drugs-in-disasters-or-emergencies for information on how to get needed care during a disaster.

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

SECTION 4	What if you're billed directly for the full cost of covered services?
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If you paid more than our plan cost-sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1	If services aren't covered by our plan, you must pay the full cost
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Trinity Health Plan of Michigan Glory No RX (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

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

SECTION 5 Medical services in a clinical research study

Section 5.1	What is a clinical research study?
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A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

Section 5.2	Who pays for services in a clinical research study
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Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

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

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

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

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

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

Get more information about joining a clinical research study

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

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www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution?

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care;
 - – *and* – You must get approval in advance from our plan before you're admitted to the facility or your stay won't be covered.

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Trinity Health Plan of Michigan inpatient hospital benefits apply. See Chapter 4, Section 2 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	You won't own some durable medical equipment after making a certain number of payments under our plan
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Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

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 Trinity Health Plan of Michigan Glory No RX (HMO), however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we'll 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 didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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

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

Section 7.2	Rules for oxygen equipment, supplies, and maintenance
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If you qualify for Medicare oxygen equipment coverage, Trinity Health Plan of Michigan Glory No RX (HMO) will cover:

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

If you leave Trinity Health Plan of Michigan Glory No RX (HMO) or no longer medically require oxygen equipment, 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 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Trinity Health Plan of Michigan Glory No RX (HMO). This section also gives information about medical services that aren't covered. It also explains limits on certain services.

Section 1.1	Out-of-pocket costs you may pay for covered services
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Types of out-of-pocket costs you may pay for covered services include:

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

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

Section 1.2	What is the most you'll pay for Medicare Part A and Part B covered medical services?
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Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This

limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$6,500.**

The amounts you pay for copayments and coinsurance (% of total cost) for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with a double asterisk (**) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$6,500, you'll not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3	Providers aren't allowed to balance bill you
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As a member of Trinity Health Plan of Michigan Glory No RX (HMO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)

- If you think a provider has balance billed you, call Member Services at 1-800-240-3851 (TTY users call 711).

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

The Medical Benefits Chart on the next pages lists the services Trinity Health Plan of Michigan Glory No RX (HMO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's an emergency or urgent care or unless our plan or a network provider has received a prior authorization from our plan. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance from us (sometimes called prior authorization). Covered services that can need approval in advance are marked in the Medical Benefits Chart by an asterisk. Please refer to the website www.thpmedicare.org/michigan/ for the most updated list of services that need prior authorization for your plan. In addition, the following services not listed in the Benefits Chart require prior authorization:

Air Mileage – Fixed Wing (FW) (per statute mile)

Air Mileage – Rotary Wing (RW) (per statute mile)

Non-Emergent – Air Service, Transport, One-Way, Fixed Wing (FW)

Non-Emergent – Air Service, Transport, One-Way, Rotary Wing (RW)

Chiropractic Services – you or your provider must get an approval from our plan before our plan will pay for services exceeding the Medicare benefit limits.

Diabetic Supplies and Services – you or your provider must get an approval from our plan before our plan will pay for supplies or services exceeding the benefit limits.

Durable medical equipment (DME) and related supplies – you or your provider must get an approval from our plan before we 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)

Out-of-Network Care (for HMO members)

Outpatient Services – Select Services

Power Mobility Devices

Prosthetic devices and related supplies – you or your provider must get an approval from our plan before Mount Carmel 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)

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original

Medicare, look in your *Medicare & You 2026* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
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.	\$0 copay for visits using web/phone-based technologies. \$0 copay for using the nurse hotline benefit. \$0 copay for virtual care visits.
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.	

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Covered Service	What you pay
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for 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 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments can be administered annually. Treatment must be discontinued if the patient isn't improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) can 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 can furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. 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.	\$20 copay for each Medicare-covered visit.

Covered Service	What you pay
To find an acupuncturist in our plan's network, please visit www.thpmedicare.org/michigan/find-a-provider .	
Acupuncture (Non-Medicare covered routine benefit)* Acupuncture is often used for pain management including chronic pain, cancer treatment support, headaches, insomnia, anxiety, and addiction support. Benefit includes: • 12 visits every year To find an acupuncturist in our plan's network, please visit www.thpmedicare.org/michigan/find-a-provider . *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	\$20 copay for each routine visit. **

Covered Service	What you pay
Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	\$275 copay for each Medicare-covered ground ambulance service. \$325 copay for each Medicare-covered air ambulance service. Cost sharing applies to each one-way trip. No additional copay for a round trip if the round trip is provided within the same calendar day by the same provider. Ambulance coverage excludes transportation by wheelchair, van, ambulette and trips to or from a physician's office.
Annual physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share can apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits don't need to be scheduled 12 months apart but are limited to one visit each calendar year.	\$0 copay for an annual physical exam.

Covered Service	What you pay
 Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. If lab, diagnostic or therapeutic services are provided during the same visit, a copay or coinsurance can apply.
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	\$10 copay for each Medicare-covered cardiac rehabilitation services visit. \$10 copay for each Medicare-covered intensive cardiac rehabilitation services visit.

Covered Service	What you pay
 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 can discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that's 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're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
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.). *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	\$10 copay for each Medicare-covered chiropractic visit.

Covered Service	What you pay
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Please refer to other service sections within this benefit chart for copay amounts that may apply.

Covered Service	What you pay
 Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to a \$0 copay. There is no outpatient surgery or ambulatory surgical center copay for a screening exam of the colon when it includes a biopsy or removal of any growth during the procedure if you get these services from a network provider. Refer also to the Outpatient Surgery section within this benefit chart (Chapter 4, Section 2).

Covered Service	What you pay
• Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:	\$30 copay for Medicare-covered dental services.

Covered Service	What you pay
Preventive dental services: • 2 oral exams every year** • 2 cleanings every year** • 2 fluoride treatments every year** • 1 X-ray; x-ray benefit is for bitewing x-rays two to eight per calendar year, vertical bitewing x-rays one per consecutive 36 months, or one full mouth x-ray every 36 consecutive months** • 1 visit for other diagnostic dental services; intraoral tomosynthesis benefit is for two to eight x-rays per calendar year for bitewing and periapical, or 1 per consecutive 36 months for comprehensive series.** • 1 visit for other preventive dental services; space maintainer benefit is for 1 per consecutive 60 months, re-cement or re-bond of space maintainer is for 1 per consecutive 6 months, or removal of fixed space maintainer is unlimited.**	\$1,000 maximum plan coverage amount every year for diagnostic and preventive dental services. This amount is combined with the non-Medicare-covered comprehensive dental services benefit. \$0 copay for each preventive dental office visit. Cost per office visit includes exams, X-rays, other diagnostic dental services, cleanings, fluoride treatments, other preventive dental services.

Covered Service	What you pay
Dental services (continued) Comprehensive dental services: • Restorative services: 1 visit; frequencies include unlimited, one per consecutive 6 months, one per consecutive 12 months, or one per consecutive 60 months depending on service code.** • Endodontics services: 1 visit; frequencies include one per tooth per lifetime, two per tooth per lifetime, or unlimited depending on service code.** • Periodontics services: 1 visit; frequencies include unlimited, two per calendar year, two per consecutive 12 months, one per consecutive 36 months, or one per quadrant per consecutive 24 or 36 months depending on service code.** • Oral and maxillofacial surgery services: 1 visit; frequency includes unlimited, 1 per site per visit, consecutive 36 months, or lifetime, 1 per tooth per lifetime, 1 per consecutive 36 months, or 1 biopsy per site per visit depending on service code.** • Adjunctive general services: 1 visit; frequency is unlimited, 1 per consecutive 6 months, or 2 per calendar year depending on the service code.** Important: HMO members who have the preventive and comprehensive dental, as well as those who purchase the additional Optional Supplemental Dental benefit, must receive dental care from a Dental Benefit Providers, Inc. network provider for dental services to be covered. Dental benefits are administered by Dental Benefit Providers, Inc. Please refer to our plan website www.thpmedicare.org/michigan/ and click on the Plan & Benefits tab, then click on Discover Member Extras, and find the Dental section to search dental codes.	\$1,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. This amount is combined with the diagnostic and preventive dental services benefit. 50% of the total cost for restorative services. 70% of the total cost for endodontics services. 70% of the total cost for periodontics services. 50% of the total cost for oral and maxillofacial surgery services. \$0 copay for adjunctive general services.

Covered Service	What you pay
For more information or assistance finding a dental plan network provider near you, call your dental plan administered by Dental Benefit Providers, Inc. at 1- 866-209-3212 (TTY 711), 8 a.m. - 8 p.m., Monday - Friday. **Amounts you pay for some services don't 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.	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 had any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests can also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You can be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Covered Service	What you pay
 Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: - Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. - For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. - Diabetes self-management training is covered under certain conditions. The following formulary diabetic supplies are available: Meters: Accu-chek and True Metrix Test Strips: Accu-chek test strips and True Metrix test strips *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit. An office or facility copay can apply if other services are provided during your visit. \$0 copay for Medicare-covered diabetic monitoring supplies. Refer to the Provider/Pharmacy Directory for a complete list of diabetic supply providers in our plan's network. Coverage Criteria and Limits (Exceptions Require Prior Authorization): - Insulin Dependent: Up to 3 times per day - Non-insulin Dependent: Up to 2 times per day 20% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. \$0 copay for Medicare-covered diabetes self-management training services.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. We included a copy of our <i>DME Supplier Directory</i> in the envelope with this document. The most recent list of suppliers is also available on our website at www.thpmedicare.org/michigan/find-a-provider. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	20% of the total cost for Medicare-covered durable medical equipment. Your cost sharing for Medicare oxygen equipment coverage is 20% of the total cost, every month. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in Trinity Health Plan of Michigan Glory No RX (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Trinity Health Plan of Michigan Glory No RX (HMO) is 20% coinsurance.
 EKG following the “Welcome to Medicare” visit The screening EKG, when done as a referral from the Welcome to Medicare preventative visit, is only covered once during a beneficiary's lifetime.	\$0 copay for an EKG following the “Welcome to Medicare” visit.

Covered Service	What you pay
Emergency care Emergency care refers to services that are: - Furnished by a provider qualified to furnish emergency services, and - Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have had medical symptoms that require immediate medical attention to prevent loss of life (and, if you’re a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms can be an illness, injury, severe pain, or a medical condition that’s quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care is covered worldwide. Please see Worldwide emergency and urgently needed care services row for details.	\$130 copay for each Medicare-covered emergency room visit. ER cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital. If you get emergency care outside of the U.S., you can be required to pay for that care and have our plan reimburse you once you return home. Refer to Chapter 7 for information.

Covered Service	What you pay
 Fitness benefit (One Pass®) Benefits include: Fitness benefit provided through the One Pass® program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You have access to a wide variety of in-network gyms. • Online Fitness: You have access to live, digital fitness classes and on-demand workouts. • Fitness and Social Activities: You also have access to groups, clubs and social events. • Brain Health: Access to online brain training made just for you. For more information about participating gyms and fitness locations, or the program's benefits, please visit www.YourOnePass.com or call 1-877-504-6830 (TTY: 711).	\$0 copay for the fitness benefit. Benefit includes memory fitness and physical fitness. You must use One Pass® to access this benefit.

Covered Service	What you pay
Hearing services Hearing Exam: 1 routine hearing exam per year.** Hearing Aids: Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options for an additional \$50 per aid. Benefit is combined in- and out-of-network. You must see a TruHearing provider to use this benefit. Call 1-833-414-9234 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit doesn't include or cover any of the following: • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that aren't TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by our plan.	\$0 copay for each routine hearing exam (up to one per calendar year).** \$30 copay for each Medicare-covered exam to diagnose and treat hearing and balance issues. \$599 to \$899 copay for one TruHearing Advanced hearing aid** and one TruHearing Premium hearing aid** (respectively). \$50 additional cost per aid for optional hearing aid rechargeability.** \$0 copay for first year of follow-up visits for hearing aid fitting and adjustments.**

Covered Service	What you pay
**Amounts you pay for some services don't 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 If you are pregnant, we cover: - Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: - Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) - Physical therapy, occupational therapy, and speech therapy - Medical and social services - Medical equipment and supplies	\$0 copay for Medicare-covered home health services. 20% coinsurance when Part B medical equipment and supplies are billed separately.

Covered Service	What you pay
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Prosthetics and supplies ***You may pay less than a 20% coinsurance for certain Part B rebatable drugs. If the drug price has increased at a rate faster than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.	20% of the total cost for Medicare-covered home infusion therapy services.*** Additional copay/coinsurance can apply for professional services based on the provider delivering the service.

Covered Service	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.	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 Trinity Health Plan of Michigan Glory No RX (HMO). Hospice consultations are included as part of inpatient hospital care. Physician service cost-sharing can apply for outpatient consultations.

Covered Service	What you pay
For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <u>For services covered by Trinity Health Plan of Michigan Glory No RX (HMO) but aren't covered by Medicare Part A or B:</u> Trinity Health Plan of Michigan Glory No RX (HMO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. Note: If you need non-hospice care (care that's not related to your terminal prognosis), 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.	

Covered Service	What you pay
 Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. You're covered for 90 days per benefit period for Medicare-covered inpatient hospital stays. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	For Medicare-covered inpatient hospital stays, you pay: \$295 copay per day for days 1-7; \$0 copay per day for days 8-90. For additional days after reaching the Medicare-covered benefit limit, you pay \$0 copay for days 91 and beyond.

Covered Service	What you pay
Inpatient hospital care (continued) - Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers can be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you can choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Trinity Health Plan of Michigan Glory No RX (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. - Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) starts with the first pint of blood you need. - Physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>. If you're not sure if you're an inpatient or an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet called <i>Medicare Hospital Benefits</i>. This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	If you get 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.

Covered Service	What you pay
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. You get up to 190 days of Medicare-covered inpatient psychiatric hospital care in a lifetime. The 190-day limit doesn't 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 for more information.	For Medicare-covered inpatient mental health care stays, you pay: \$295 copay per day for days 1-7; \$0 copay per day for days 8-90.

Covered Service	What you pay
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay* If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	You pay 100% of all charges if you choose to use a non-plan hospital without prior authorization (excluding emergency admissions), or at the point our plan determines your stay isn't (or is no longer) covered based on medical necessity. In some cases, you're entitled to get listed services after your SNF days have been exhausted or are no longer covered. Physician services See <i>Physician/Practitioner Services, Including Doctor's Office Visits</i> row. Diagnostic and radiological services, surgical dressings, and splints See <i>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</i> row. Prosthetics, orthotics, and outpatient medical/therapeutic supplies See <i>Prosthetic and Orthotic Devices and Related Supplies</i> row. Physical, speech, and occupational therapy services

Covered Service	What you pay
	See <i>Outpatient Rehabilitation Services</i> row.
 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 the first year you get 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 can be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered Service	What you pay
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you're getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you can need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you can need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	For certain Part B drugs, you can be required to try a different drug first. 20% of the total cost for Medicare Part B chemotherapy and radiation drugs.*** 20% of the total cost for other Medicare Part B drugs.*** Insulin furnished through a Durable Medical Equipment (DME) item such as an insulin pump is subject to a coinsurance cap of a \$35 copay for a one-month's supply of insulin. Plan service category or plan level deductibles don't apply.

Covered Service	What you pay
Medicare Part B drugs* (continued) • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth, if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv[®], and the oral medication Sensipar[®] • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics	

Covered Service	What you pay
Medicare Part B drugs* (continued) - Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen[®], Procrit[®], Retacrit[®], Epoetin Alfa, Aranesp[®], Darbepoetin Alfa, Mircera[®], or Methoxy polyethylene glycol-epoetin beta) - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases - Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that can be subject to Step Therapy: www.thpmedicare.org/michigan/my-medications/prior-authorization. We also cover some vaccines under our Part B drug benefit. *Prior authorization rules can apply for select services. Refer to Chapter 4, Section 2 for more information. ***You may pay less than a 20% coinsurance for certain Part B rebatable drugs. If the drug price has increased at a rate faster than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.	
 Obesity screening and therapy to promote sustained weight loss If you have had a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Covered Service	What you pay
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • 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	\$30 copay for Medicare-covered opioid treatment services.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) starts with the first pint of blood you need. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	Outpatient X-rays \$30 copay for Medicare-covered services. Therapeutic radiology services \$60 copay for Medicare-covered services (such as radiation treatment for cancer). Medical supplies 20% of the total cost for Medicare-covered supplies. Lab services \$0 copay for Medicare-covered services. Blood services \$0 copay for Medicare-covered services. Diagnostic tests and procedures \$30 copay for Medicare-covered services. Diagnostic radiology services \$300 copay for Medicare-covered services (such as MRIs and CT scans). 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

Covered Service	What you pay
	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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet called <i>Medicare Hospital Benefits</i>. This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	\$285 copay per stay for Medicare-covered outpatient hospital observation services.

Covered Service	What you pay
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 aren't 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're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient ask the hospital staff. You can also find more information in a Medicare fact sheet called <i>Medicare Hospital Benefits</i>. This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. 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 for more information. ***You may pay less than a 20% coinsurance for certain Part B rebatable drugs. If the drug price has increased at a rate faster	\$295 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility. \$0 copay for lab tests. \$30 copay for X-ray services. \$300 copay for diagnostic radiological PET scan services. \$300 copay for all other diagnostic radiological services other than PET scan services. \$60 copay for therapeutic radiological services. 20% of the total cost for Part B drugs and biologicals when provided during an outpatient hospital service.*** \$0 copay per visit to a Coumadin clinic. \$30 copay per visit to a respiratory therapy department.

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

Covered Service	What you pay
than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.	Refer also to the Outpatient Diagnostic Tests and Therapeutic Services and Supplies, the Outpatient Mental Health Care, Outpatient Hospital Observation, and the Partial Hospitalization sections within this benefit chart (Chapter 4, Section 2) for other copay amounts.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	\$30 copay for each Medicare-covered individual therapy visit with a psychiatrist. \$30 copay for each Medicare-covered group therapy visit with a psychiatrist. \$30 copay for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist). \$30 copay for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).

Covered Service	What you pay
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	\$20 copay for each Medicare-covered occupational therapy visit. \$20 copay for each Medicare-covered physical and/or speech therapy visit.
Outpatient substance use disorder 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.	\$40 copay for each Medicare-covered individual therapy visit. \$40 copay for each Medicare-covered group therapy visit.

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>.	For Medicare-covered services at an ambulatory surgical center, you pay \$295 copay. For Medicare-covered services at an outpatient hospital facility, you pay \$295 copay. For some non-invasive surgical procedures and tests (for example, but not limited to: endoscopy, liver biopsy, diagnostic colonoscopy, insertion of urine catheter and certain injections) the outpatient surgery copay will apply. Please contact Member Services with any questions. Refer to the Outpatient Diagnostic Tests and Therapeutic Services and Supplies and the Outpatient Hospital sections within this benefit chart (Chapter 4, Section 2) for other copay amounts. Coinsurance and copays are separate member responsibilities. If you get multiple services from the same provider on the same date, you'll be responsible for the highest copay for services

Covered Service	What you pay
Over-the-counter allowance OTC items are drugs and health-related products that don't require a prescription. Members get 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 and National branded products without the need for a prescription. Eligible members can 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 http://www.cvs.com/benefits. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	in addition to coinsurance, if applicable. \$75 maximum plan coverage amount every 3 months for OTC items.** Unused portion does not carry over to the next period. Member is responsible for the difference if the total exceeds the quarterly allowance. The quarterly allowance can only be exceeded at the retail locations. Orders placed over the phone and online must total the quarterly allowance or less. You must use the CVS/OTCHS to access this benefit.

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. <i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you receive in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	\$55 copay per day for Medicare-covered partial hospitalization services and intensive outpatient services.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits* Covered services include: • Medically-necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your primary care physician, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: those rendered by a primary care physician, specialist, mental health provider, or psychiatrist. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Members should call their provider first to inquire if telehealth services are available before seeking treatment. ○ Telehealth services can be conducted by phone, computer, tablet, and/or other video-enabled technology. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	\$0 copay for each Medicare-covered primary care visit. \$30 copay for each Medicare-covered specialist visit. For each Medicare-covered visit with other health care professionals (such as nurse practitioners and physician assistants), you pay \$0 to \$30 copay. For additional telehealth benefits, you pay the copay associated with primary care physician services, physician specialist services, individual sessions for mental health specialty services, individual sessions for psychiatric services. \$60 copay for therapeutic radiological services. 20% of the total cost for durable medical equipment, the cost of allergy serum, or other Part B drugs administered or dispensed in a physician's office.***

• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment Consultation your doctor has with other doctors by phone, internet, or electronic health record. • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	\$30 copay for basic hearing and balance exam. \$30 copay for X-rays (examples include but aren't limited to a basic film X-ray of an ankle, shoulder, or foot). \$30 copay for diagnostic tests (examples include but aren't limited to an electrocardiogram [ECG/EKG], duplex scan of the heart, and esophageal function test in a physician's office. \$300 copay for diagnostic radiological PET scan services. \$300 copay for all other diagnostic radiological services other than PET scan services. \$0 copay for lab tests. \$30 copay for non-routine dental care. Coinsurance and copays are separate member responsibilities. If you get multiple services from the same provider on the same date, you'll be
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Covered Service	What you pay
***You may pay less than a 20% coinsurance for certain Part B rebatable drugs. If the drug price has increased at a rate faster than the rate of inflation, the amount you pay will be based on a lower, inflation-adjusted price.	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	\$30 copay for each Medicare-covered podiatry services visit.

Covered Service	What you pay
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.
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 can be eligible to get nutritious meals to help you recover from your injuries or manage your health conditions. Meals can not be merely for convenience or comfort purposes. Meals will be coordinated by GA Foods and delivered to your home. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	\$0 copay for covered meals** You must use GA Foods to access this benefit.
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. \$0 copay for an annual Medicare-covered digital rectal exam.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to <i>Vision Care</i> later in this table for more detail. *Prior authorization rules may apply for select services. Refer to the list in Chapter 4, Section 2 for more information.	20% of the total cost for Medicare-covered prosthetic and orthotic devices. 20% of the total cost for related Medicare-covered supplies.
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.	\$10 copay for each Medicare-covered pulmonary rehabilitation services visit.
 Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered Service	What you pay
 Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible members are: people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which can be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay
 Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
 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 only cover these counseling sessions as a preventive service if they're provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to the section, Medicare Part B drugs in this table.	\$0 copay for Medicare-covered kidney disease education services (a copay will apply if you also are treated for an existing medical condition during the visit). 20% of the total cost for Medicare-covered dialysis services. \$0 copay per visit for self-dialysis training if provided in a primary care provider's office. \$30 copay per visit for self-dialysis training if provided in a specialist's office. \$0 copay for home health support services. No additional cost for dialysis treatments while admitted to a hospital. 20% coinsurance for home dialysis equipment and supplies.

Covered Service	What you pay
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) You're covered for 100 days per benefit period for Medicare-covered SNF stays. Notification needs to be provided within 2 days of admission. Covered services include but aren't 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 (as well as other components of blood) starts with the first pint of blood you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you can 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)	Inpatient hospital stay is not required prior to admission. For Medicare-covered SNF stays, you pay: \$0 copay per day for days 1-20; \$218 copay per day for days 21-60; \$0 copay per day for days 61-100. A benefit period starts the day you're admitted to an SNF. The benefit period ends when you've not received hospital or SNF care for 60 days in a row. If you're admitted to the facility after one benefit period ends, a new benefit period starts. There is no limit to the number of benefit periods you can have.

Covered Service	What you pay
• A SNF where your spouse or domestic partner is living at the time you leave the hospital  Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) <u>If you use tobacco, but don't have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. <u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that can be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you'll pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
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 can 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.	\$10 copay for each Medicare-covered SET visit.

Covered Service	What you pay
Supplemental Vision/Hearing Allowance (Flexible Benefit Card)** Members get \$150 annual allowance on their Flexible Benefit Card (see description below), which can be used towards certain out-of-pocket costs for our plan’s covered Vision and/or Hearing benefits, allowing members to extend their coverage. For a complete description of covered Vision and Hearing services, please refer to the Vision and Hearing benefit sections within this Medical Benefits Chart. Services must be provided where the primary business is Vision Services or Hearing Services, and the provider must accept Visa. Unused amounts expire at the end of our plan year. Current members who already have a Flexible Benefit Card can continue to use that same Flexible Benefit Card in 2026. New members will get their Flexible Benefit Card in a separate mailing with additional information. The Flexible Benefit Card will not require activation, and will be ready to use upon arrival. **Amounts you pay for some services don’t count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	\$0 copay You must use an in-network Vision or Hearing provider to access this benefit.

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area of our plan, or even if you're inside our plan's service area of our plan, it is unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, like annual checkups, aren't considered urgently needed even if you're outside the service area of our plan or our plan network is temporarily unavailable. Urgent care is covered worldwide. Please see Worldwide emergency and urgently needed care services row for details.	\$45 copay for each Medicare-covered visit. \$45 copay per pharmacy-based mini clinic visit within the U.S. \$130 copay per urgent care visit outside the U.S.

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

Covered Service	What you pay
 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 for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older- and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.	Medicare-covered vision care \$30 copay for each eye exam to diagnose and treat diseases and conditions of the eye. \$0 copay for an annual glaucoma screening. \$0 copay for an annual diabetic eye exam. \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
Additional benefits include: • Routine eye exams: 1 exam every year	\$0 copay for each routine eye exam visit.** (If a medical condition is found and/or treated during a routine eye exam, a copay can apply.)

Covered Service	What you pay
• Eyeglasses (lenses and frames) • Eyeglasses lenses • Eyeglasses frames • Contact lenses You're responsible for any amount above the coverage limit. Coverage with your vision plan is administered by Spectera, Inc. and includes frames, lenses and contact lenses, and must be obtained through an in-network Spectera, Inc. contracted provider. It is your responsibility to provide insurance at the time of service to get the benefit. The benefit cannot be combined with any in-store promotional offers or discounts. Exam doesn't cover Contact Fittings. The Contact Fitting isn't a covered benefit. Note: This allowance doesn't apply to eyewear obtained following cataract surgery. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	\$225 maximum plan coverage amount every year for all non-Medicare-covered eyewear.

Covered Service	What you pay
Visitor/Traveler Benefit When traveling outside the state of Michigan, but within the United States and its territories, members can 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 isn't 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. • 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 aren't eligible under the visitor travel benefit. • The visitor/traveler benefit is designed for members that are traveling out of their home state for more than seven (7) days but less than one hundred eighty (180) days, and wish to seek care for routine services. Routine services include services such as an annual wellness visit, visit with a specialist for an established medical condition or any non-emergent care received from an out-of-network provider. Urgent/Emergent care, such as a visit to an urgent care or emergency room, isn't considered routine, and is covered under your regular benefits with our plan. Members can have multiple periods of traveling for a total of up to twelve months per calendar year. Members must contact our plan by calling Member Services when they return to	\$3,500 allowance towards visitor/travel covered, medically necessary services from out-of-network providers when traveling outside the state of Michigan. Amounts don't carry over from year to year.

Covered Service	What you pay
the service area; failure to notify our plan can result in a delay in claims processing. Care received while out of the country or on/related to a cruise ship, aren't covered under the travel benefit.	
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots and referrals for other care if needed). Important: We cover the <i>Welcome to Medicare</i> preventive visit only within the first 12 months you have had Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.	There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.

Covered Service	What you pay
Worldwide emergency and urgently needed care services Benefit includes: - Emergency care - Urgently needed care - Emergency/urgently needed care transportation services	\$130 copay for each emergency care visit outside of the United States and its territories. Worldwide ER services cost sharing is waived if you are admitted to the hospital within 48 hours for the same condition. \$130 copay for each urgently needed care visit outside of the United States and its territories. \$275 to \$325 copay for each emergency/urgently needed care transportation service outside of the United States and its territories. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital. If you get emergency care outside of the U.S., you can be required to pay for that care and have our plan reimburse you once you return home. Refer to Chapter 7 for information.

Section 2.1	Extra optional supplemental benefits you can buy
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Our plan offers some extra benefits that aren't covered by Original Medicare and are 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 can 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.

Covered Service	What You Pay
Optional Dental Services** Members can separately purchase the Optional Supplemental Dental benefit. Our plan offers the Dental Silver benefit. The premium for the Dental Silver benefit is \$14 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. Important: For more information or assistance finding a dental plan network provider near you, call your dental plan administered by Dental Benefit Providers, Inc. at 1-866-209-3212 (TTY: 711), 8 a.m. – 8 p.m., Monday - Friday. HMO members who separately purchase the Optional Supplemental Dental benefit must receive both preventive and comprehensive care from a Dental Benefit Providers, Inc. network provider for dental services to be covered. Dental benefits are provided by Dental Providers, Inc. Please refer to our plan website www.thpmedicare.org/michigan/ and click on the Plan & Benefits tab, then click on Discover Member Extras, and find the Dental section to search dental codes. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	In-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.

Covered Service	What You Pay
Optional Dental Services** Members can separately purchase the Optional Supplemental Dental benefit. Our plan offers the Dental Gold benefit. The premium for the Dental Gold benefit is \$39 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. Important: For more information or assistance finding a dental plan network provider near you, call your dental plan administered by Dental Benefit Providers, Inc. at 1-866-209-3212 (TTY: 711), 8 a.m. – 8 p.m., Monday - Friday. HMO members who separately purchase the Optional Supplemental Dental benefit must receive both preventive and comprehensive care from a Dental Benefit Providers, Inc. network provider for dental services to be covered. Dental benefits are provided by Dental Benefit Providers, Inc. Please refer to our plan website www.thpmedicare.org/michigan/ and click on the Plan & Benefits tab, then click on Discover Member Extras, and find the Dental section to search dental codes. **Amounts you pay for some services don't count toward your maximum out-of-pocket amount. Refer to Chapter 4, Section 1.2 for more information.	In-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.

Enrolling in our Optional Supplemental Dental Plans

As a member of our plan, you can voluntarily choose to enroll in one of the Optional Supplemental Dental Plans. The premium for the Dental Silver Plan is \$14 per month. The premium for the Dental Gold plan is \$39 per month. You'll pay this amount in addition to your Medicare Part B premium and monthly plan premium (if applicable). New members can elect an Optional Supplemental Dental Plan at the time of their enrollment with coverage beginning when they become effective with our 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 get and pay for them throughout the calendar year. Members can voluntarily drop or discontinue the Optional Supplement Dental benefit at any time during the calendar year by sending our 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're disenrolled from an Optional Supplemental Dental Plan during the year, you must wait until fall to enroll again during the Annual Enrollment Period. For more information about ending your membership, please refer to Chapter 8. Please know that all premiums must be paid current (in full) before we can accept your request to purchase this Optional Supplemental Dental Plan.

If you get behind on your monthly premium payments, future payments will be applied first to the oldest outstanding balances you owe for your health plan premiums. Please keep your payments current to avoid unnecessary inconvenience and confusion. If you don't keep your health plan premiums and Optional Supplemental Dental Plan premiums paid current, it could result in your disenrollment from our 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'll send letters to you any time our records indicate you have an outstanding balance on your account.

Section 2.2	Get care using our plan's optional visitor/traveler benefit
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If you don't permanently move, but you're 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 Michigan but within the United States, which will allow you to remain enrolled when you're outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Please contact our plan for assistance in locating a provider when using the visitor/traveler benefit.

This benefit has an annual coverage maximum of \$3,500 per calendar year (amounts don't 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 isn't initiated prior to traveling, member will not be able to access the visitor travel benefit.
- Members can 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.
- 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 aren't eligible under the visitor/ travel benefit.
- The visitor/traveler benefit is designed for members that are traveling out of their home state for more than seven (7) days but less than one hundred eighty (180) days, and wish to seek care for routine services. Routine services include services such as an annual wellness visit, visit with a specialist for an established medical condition or any non-emergent care received from an out-of-network provider. Urgent/Emergent care, such as a visit to an urgent care or emergency room, isn't considered routine, and is covered under your regular benefits with our plan. Members can have multiple periods of traveling for a total of up to twelve months per calendar year. Members must contact our plan by calling Member Services when they return to the service area; failure to notify our plan can result in a delay in claims processing.
- Care received while out of the country or on/related to a cruise ship, aren't covered under the travel benefit.

If you're in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If don't return to our plan's service area within 12 months, you'll be disenrolled from our plan.

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

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

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

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

Services not covered by Medicare Covered only under specific conditions	
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 is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	• Can 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.)

Services not covered by Medicare	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition
Full-time nursing care in your home.	Not covered under any condition
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments).	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition
Private room in a hospital.	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.

Services not covered by Medicare	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	• One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Routine foot care	• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

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

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

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

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

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

1. When you've got emergency or urgently needed medical care from a provider who's not in our plan's network

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.

- If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've 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 got the service or item.

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

Trinity Health Plan of Michigan
Attn: Member Services
3100 Easton Square Place
Suite 300
Columbus, OH 43219

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

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

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

Section 3.1	If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal
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If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1	Our plan must honor your rights and cultural sensitivities
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Section 1.1	We must provide information in a way that works for you and is consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)
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Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-240-3851 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with the plan 1-800-240-3851 (TTY 711). You can also file a complaint with

Chapter 6 Your rights and responsibilities

Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We don't require you to get referrals. We don't require you to get referrals to go to network providers.

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

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

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

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

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

How do we protect the privacy of your health information?

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

Chapter 6 Your rights and responsibilities

- Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services 1-800-240-3851 (TTY users call 711).

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

Revised: June 1, 2024

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

We're required by the Health Insurance Portability and Accountability Act of 1996, and the Health Information Technology for Economic and Clinical Health Act (found in Title XIII of the American Recovery and Reinvestment Act of 2009) (collectively referred to as "HIPAA"), as amended from time to time, to maintain the privacy of individually identifiable health information (this information is "protected health information" and is referred to herein as "PHI"). We're also required to provide patients with a Notice of Privacy Practices regarding PHI. We'll only use or disclose your PHI as permitted or required by applicable state and federal law. This notice applies to your PHI under our control including the medical records generated by us.

We understand that your health information is highly personal, and we're committed to safeguarding your privacy. Please read this notice of Privacy Practices thoroughly. It describes how we'll use and disclose your PHI.

This notice pertains to the privacy practices of Trinity Health Plan of Michigan. When this notice says "we", "us", "our", it means Trinity Health Plan of Michigan.

I. Permitted Use or Disclosure

Chapter 6 Your rights and responsibilities

- A. Treatment:** We'll use and disclose your PHI to provide, coordinate, or manage your health care and related services to carry out treatment functions. The following are examples of how we'll use and/or disclose your PHI:
- i. To your physician, hospitals, pharmacies, and other health care providers who have a legitimate need for such information in your care and treatment.
 - ii. To coordinate your treatment with health care providers.
 - iii. To health care providers in connection with preventive health, early detection and disease and case management programs.
 - iv. To provide you with information about treatment or other health-related benefits or services.
- B. Payment:** We'll use and disclose PHI about you for payment purposes. The following are examples of how we'll use and/or disclose your PHI:
- i. To help pay for your covered services, we can use and disclose PHI in conducting medical necessity and utilization 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 appeals.
 - ii. To another insurance company, third party payer, third party administrator, or other health care provider (or their duly authorized representatives) for payment purposes such as determining coverage, pre-approval/authorization for treatment, billing, claims management, reimbursement audits, etc.
 - iii. To determine whether a treatment is a covered benefit and the payment amount.
- C. Health Care Operations:** We'll use and disclose your PHI for health care operations purposes. The following are examples of how we'll use and/or disclose your PHI:
- i. For case management, quality assurance, utilization, accounting, auditing, discharge planning, population health and wellness activities relating to improving health or reducing health care costs, education, underwriting and premium rating, administration of pharmacy benefit programs, coordination of benefits, credentialing activities, and other general administrative activities including resources and data management.
 - ii. To consultants, accountants, auditors, attorneys, transcription companies, information technology and cloud storage providers, etc.
 - iii. We're specifically prohibited from using or disclosing PHI that's genetic information of an individual for underwriting purposes as required by the Genetic Information and Nondiscrimination Act (GINA).
- D. Other Uses and Disclosures:** As part of treatment, payment, and health care operations we can also use your PHI for the following purposes:

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- i. **Information and Health Promotion Activities:** We can use and disclose some of your PHI for certain health promotion activities. For example, your name and address will be used to send you newsletters or general communications. We can also send you specific information based on your own health concerns.
- ii. **Research:** Under certain circumstances, we can 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 get.

E. More Stringent State and Federal Laws: The State law of Michigan is more stringent than HIPAA in several areas. Certain federal laws also are more stringent than HIPAA. We'll continue to abide by these more stringent state and federal laws.

- i. **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 alcohol and substance abuse treatment.
- ii. **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. In cases where we provide treatment to a patient who resides in a neighboring state, we'll abide by the more stringent applicable state law.

F. Health Information Exchange: We can share your health records electronically or otherwise with Health Information Exchanges ("HIEs") that exchange health records with other HIEs. Our Ministry also uses data exchange technology (such as direct messaging services, health information services provider ("HISP"), and provider portals) with its Electronic Health Record ("EHR") to share your health records for permitted purposes including continuity of care and treatment. HIEs and data exchange technology enable the sharing of your health records to improve the quality of health care services provided to you (e.g., avoiding unnecessary duplicate testing). The shared health records will include, if applicable, sensitive diagnoses such as HIV/AIDS, sexually transmitted diseases, genetic information, mental health, and alcohol/substance abuse, etc. HIEs and data exchange technology providers function as our business associate and, in acting on our behalf, they will transmit, maintain and store your PHI for treatment, payment and health care operations and other permitted purposes. HIEs and data exchange technologies are required to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of your medical information. Applicable law can provide you rights to

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restrict, opt-in, or opt-out of HIE(s). For more information, please contact Member Service at 1-800-240-3851.

II. Permitted Use or Disclosure with an Opportunity for You to Agree or Object

- A. Family/Friends:** We'll disclose PHI about you to a friend or family member who is involved in or paying for your medical care. You have a right to request that your PHI not be shared with some or all your family or friends. In addition, we'll disclose PHI about you to an agency assisting in disaster relief efforts so that your family can be notified about your condition, status, and location.

III. Use or Disclosure Requiring Your Authorization

- A. Marketing:** Subject to certain limited exceptions, your written authorization is required in cases where our Ministry gets any direct or indirect financial remuneration in exchange for making the communication to you which encourages you to purchase a product or service or for a disclosure to a third party who wants to market their products or services to you.
- B. Research:** We'll get your written authorization to use or disclose your PHI for research purposes when required by HIPAA or clinical research laws and regulations.
- C. Psychotherapy Notes:** Most uses and disclosures of psychotherapy notes require your written authorization.
- D. Sale of PHI:** Subject to certain limited exceptions, disclosures that constitute a sale of PHI require your written authorization.
- E. Other Uses and Disclosures:** Any other uses or disclosures of PHI that aren't described in this notice of Privacy Practices can require your written authorization (if not otherwise permitted by HIPAA). Written authorizations will let you know why we're using your PHI. You have the right to revoke an authorization at any time.

IV. Use or Disclosure Permitted or Required by Public Policy or Law Without Your Authorization

- A. Law Enforcement Purposes:** We can disclose your PHI for law enforcement purposes as permitted by law, such as identifying a criminal suspect or a missing

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person or providing information about a crime victim or criminal conduct affecting you.

- B. Required by Law:** We'll disclose PHI about you when required by federal, state, or local law. Examples include disclosures in response to a court order / subpoena, mandatory state reporting (e.g., gunshot wounds, victims of child abuse or neglect), government investigations, or information necessary to comply with other laws such as workers' compensation or similar laws. We'll report drug diversion and information related to fraudulent prescription activity to law enforcement and regulatory agencies.
- C. Public Health Oversight or Safety:** We'll use and disclose PHI to avert a serious threat to the health and safety of a person or the public. Examples include disclosures of PHI to state investigators regarding quality of care or to public health agencies regarding immunizations, communicable diseases, etc. We'll 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 in product recalls, etc.
- D. Coroners, Medical Examiners, Funeral Directors:** We'll disclose your PHI to a coroner or medical examiner. For example, this will be necessary to identify a deceased person or to determine a cause of death.
- E. Organ Procurement:** We'll disclose PHI to an organ procurement organization or entity for organ, eye, or tissue donation purposes.
- F. Specialized Government Functions:** We'll disclose your PHI regarding government functions such as military, national security and intelligence activities. We'll use or disclose PHI to the Department of Veterans Affairs to determine whether you're eligible for certain benefits.
- G. Immunizations:** We'll disclose proof of immunization to a school where the state or other similar law requires it prior to admitting a student.

V. Your Health Information Rights

You have the following individual rights concerning your PHI:

- A. Right to Inspect and Copy:** Subject to certain limited exceptions, you've the right to access your PHI and to inspect and copy your PHI as long as we maintain the data.

If we deny your request for access to your PHI, we'll notify you in writing with the reason for the denial. For example, you don't have the right to psychotherapy notes

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or to inspect the information which is subject to law prohibiting access. You can have the right to have this decision reviewed.

You also have the right to request your PHI in electronic format in cases where we utilize electronic health records. You can also access information via patient portal if made available by us.

For your convenience, some of your PHI will be accessible in a patient portal. Access to additional PHI is received through an access request.

B. Right to Amend: You have the right to amend your PHI for as long our Health Ministry maintains the data. You must make your request for amendment of your PHI in writing to Member Service at 3100 Easton Square Place, Suite 300, Columbus, OH 43219 including your reason to support the requested amendment.

However, we'll deny your request for amendment if:

- i. We did not create the information;
- ii. The information isn't part of the designated record set;
- iii. The information would not be available for your inspection (due to its condition or nature); or
- iv. The information is accurate and complete.

If your request for changes in your PHI is denied, we'll notify you in writing with the reason for the denial. We'll also inform you of your right to submit a written statement disagreeing with the denial. You can ask that we include your request for amendment and the denial any time that we subsequently disclose the information that you wanted changed. We can prepare a rebuttal to your statement of disagreement and will provide you with a copy of that rebuttal.

C. Right to an Accounting: You have a right to get an accounting of the disclosures of your PHI that we have made, except for the following disclosures:

- i. To carry out treatment, payment, or health care operations;
- ii. To you;
- iii. To persons involved in your care;
- iv. For national security or intelligence purposes; or
- v. To correctional institutions or law enforcement officials.

You must make your request for an accounting of disclosures of your PHI in writing to 3100 Easton Square Place, Suite 300, Columbus, OH 43219.

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You must include the time period of the accounting, which cannot be longer than 6 years. Once during in any 12-month period, we'll provide you with an accounting of the disclosures of your PHI at no charge.

- D. Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your PHI to carry out treatment, payment or health care operations functions or to prohibit such disclosure. However, we'll consider your request but aren't required to agree to the requested restrictions.
- E. Right to Confidential Communications:** You have the right to get confidential communications of your PHI by alternative means or at alternative locations. For example, you can request that we only contact you at work or by mail. If you've provided your email, we can contact you via that email unless you request an alternate means of contact.
- F. Right to Get a Copy of This Notice:** You have the right to get a paper copy of this notice of Privacy Practices, upon request.

VI. Breach of Unsecured PHI

If a breach of unsecured PHI affecting you occurs, we're required to notify you of the breach. Such notice can be provided by our business associate on our behalf.

VII. Sharing and Joint Use of Your Health Information

- A. Business Associates** We'll share your PHI with business associates and their subcontractors contracted to perform business functions on our behalf.
- B. Your Health Care Providers and Care Coordinators** We share your PHI with other providers and care coordinators who work together to provide treatment, get payment, and conduct health care operations. Your PHI is shared electronically in multiple ways with providers involved in the delivery of care and care coordination. Your PHI can be shared via secure transmission.

- VIII. Changes to this notice.** We'll abide by the terms of the Notice currently in effect. We reserve the right to make material changes to the terms of its Notice and to make the new Notice provisions effective for all PHI that it maintains. We'll distribute / provide you with a revised notice following the revision of the Notice in cases where it makes a material change in the Notice. You can also ask for a current copy of the Notice at any time. Current copies are posted on the Ministry's webpage.

IX. Complaints.

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If you believe your privacy rights have been violated, you can file a complaint to our health plan and you can submit a complaint directly to us by mail or by calling Member Services.

Mail:

3100 Easton Square Place, Suite 300, Columbus, OH 43219

Phone: 1-800-240-3851 (TTY/TDD: 711)

8 a.m. to 8 p.m., seven days a week

We assure you that filing a complaint will in no way affect your covered services or membership in our plan—we'll not retaliate against you for filing a complaint.

You also can file a complaint with the Secretary of the Department of Health and Human Services, by

- Sending a letter to Centralized Case Management Operations, U.S Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F HHH Bldg., Washington, D.C. 20201
- Calling 1-877-696-6775
- Visiting <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>

Privacy Official – Questions / Concerns / Additional Information.

If you have any questions, concerns, or want further information regarding the issues covered by this notice of Privacy Practice or seek additional information regarding our privacy policies and procedures, please contact Member Services at 1-800-240-3851.

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

As a member of Trinity Health Plan of Michigan Glory No RX (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-800-240-3851 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.

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

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

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

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

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

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- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services at 1-800-240-3851 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with Michigan Department of Health and Human Services.

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a

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coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

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

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

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

- **Call Member Services at 1-800-240-3851 (TTY users call 711)**
- **Call your local SHIP** at 1-800-803-7174. (TTY users call 711)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-240-3851 (TTY users call 711)**
- **Call your local SHIP** at 1-800-803-7174. (TTY users call)
- **Contact Medicare**

Visit www.Medicare.gov to read the publication *Medicare Rights & Protections*.

Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-240-3851 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.

Chapters 3 and 4 give details about medical services.

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- **If you have any other health coverage in addition to our plan, or separate prescription drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.

Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.

If you have questions, be sure to ask and get an answer you can understand.

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

CHAPTER 7:

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

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-240-3851 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

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

Making an appeal

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

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

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

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

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

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

Section 4.1	Get help asking for a coverage decision or making an appeal
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- Call **Member Services** at 1-800-240-3851 (TTY users call 711)
- Get **free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-240-3851 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available on at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmedicare.org/michigan/for-members/member-forms.)
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call Member Services at 1-800-240-3851 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmedicare.org/michigan/for-members/member-forms.) This form gives that person permission to act on your behalf. It must be signed by you and by the person who you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2	Rules and deadlines for different situations
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There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

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

If you're not sure information applies to you, call Member Services at 1-800-240-3851 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5	Medical care: How to ask for a coverage decision or make an appeal
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Section 5.1	What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care
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Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

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

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3**

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

Section 5.2	How to ask for a coverage decision
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Legal Terms:

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

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

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

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

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

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

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

For fast Coverage decisions, we use an expedited timeframe.

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

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

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

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

Section 5.3	How to make a Level 1 appeal
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Legal Terms:

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

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

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

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

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

Step 2: Ask our plan for an Appeal or a Fast Appeal

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

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're 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'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we shouldn't take extra days, you can file a *fast complaint*. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4	The Level 2 appeal process
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Legal Term:

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

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

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're 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 the information related to your appeal.

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

- Tells you how to file a Level 3 appeal.

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

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

Section 5.5	If you're asking us to pay for our share of a bill you got for medical care
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Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-240-3851 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.

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

- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at 1-800-240-3851 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2	How to make a Level 1 appeal to change your hospital discharge date
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To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-240-3851 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help at Michigan Medicare Assistance Program (MMAP, Inc.) 1-800-803-7174).

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 aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.

If you meet this deadline, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

- **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-240-3851 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3	How to make a Level 2 appeal to change your hospital discharge date
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all the information 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 its decision.

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

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

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

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

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

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

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

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

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

Section 7.2	How to make a Level 1 appeal to have our plan cover your care for a longer time
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If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-240-3851 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help at 1-800-803-7174 .
- **During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

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

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

Legal Term:

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

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 7.3

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

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

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

Level 5 appeal

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

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

Making complaints

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

Section 9.1	What kinds of problems are handled by the complaint process?
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The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	Are you unhappy with the quality of the care you got (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're being encouraged to leave our 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 our plan? - 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?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: - You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. - You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. - You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or 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 9.2	How to make a complaint
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Legal Terms:

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

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

- **Calling Member Services at 1-800-240-3851 (TTY users call 711) is usually the first step.** If there is anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **Your grievance letter must be sent to us within 60 days of the event or situation that prompted your complaint.** You can be permitted additional time to file a grievance if there were extenuating circumstances found by our 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:

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

- **Upon receipt of your grievance letter**, Trinity Health Plan of Michigan 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 can also request to have Trinity Health Plan of Michigan 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 Trinity Health Plan of Michigan extending the timeframe needed to make an organization determination or a decision regarding a reconsideration request.

- If you have a complaint about Trinity Health Plan of Michigan refusing to grant a request for an expedited organization determination or reconsideration request. In some instances, Trinity Health Plan of Michigan can need additional time to give full consideration to your original grievance. In such cases, we'll ask for a 14-day extension. You'll be notified in writing if additional time is needed and you'll 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'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

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

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

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

Or

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

Section 9.4	You can also tell Medicare about your complaint
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You can submit a complaint about Trinity Health Plan of Michigan Glory No RX (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 **Ending your membership in our plan**

Ending your membership in Trinity Health Plan of Michigan Glory No RX (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

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

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

Section 2.2	You can end your membership during the Medicare Advantage Open Enrollment Period
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You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

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

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of Trinity Health Plan of Michigan Glory No RX (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you move
- If you have Michigan Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital

- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

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

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

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

Section 2.4	Get more information about when you can end your membership
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If you have any questions about ending your membership, you can:

- **Call Member Services** at 1-800-240-3851 (TTY users call 711).
- Find the information in the **Medicare & You 2026** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Trinity Health Plan of Michigan Glory No RX (HMO) when your new plan's coverage starts.
• Original Medicare <i>with</i> a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. • You'll automatically be disenrolled from Trinity Health Plan of Michigan Glory No RX (HMO) when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare <i>without</i> a separate Medicare prescription drug plan	Send us a written request to disenroll. Call Member Services at 1-800-240-3851 (TTY users call 711) if you need more information on how to do this. - You can also call Medicare at 1-800-MEDICARE (1-800-633-4227), and ask to be disenrolled. TTY users should call 1-877-486-2048. - You'll be disenrolled from Trinity Health Plan of Michigan Glory No RX (HMO) when your coverage in Original Medicare starts.

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

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

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

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

SECTION 5 **Trinity Health Plan of Michigan Glory No RX (HMO) must end our plan membership in certain situations**

Trinity Health Plan of Michigan Glory No RX (HMO) must end your membership in our 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're away from our service area for more than twelve months .
 - If you move or take a long trip, call Member Services at 1-800-240-3851 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare can have your case investigated by the Inspector General
- If you don't pay our plan premiums for 90 days.
 - We must notify you in writing that you have 90 days to pay our plan premium before we end your membership.

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-240-3851 (TTY users call 711).

Section 5.1	We <u>can't</u> ask you to leave our plan for any health-related reason
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Trinity Health Plan of Michigan Glory No RX (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

Section 5.2	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Member Services at 1-800-240-3851 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

NOTICE INFORMING PEOPLE ABOUT NONDISCRIMINATION, AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS, AND ACCESSIBILITY SERVICES

Chapter 9 Legal notices

Trinity Health understands that we all have different lived experiences, needs, identities, customs, and abilities. We are committed to providing quality, accessible, equitable care and services that are responsive to the needs of the diverse communities served.

Trinity Health Plan of Michigan welcomes all people who come to us for care, treatment, and services. We comply with all federal civil rights laws and do not exclude anyone or treat them differently because of their age, race, color, ethnicity (including limited English proficiency and primary language), national origin, religion, culture, language, physical or mental disability, socioeconomic status (including ability to pay or participation in Medicaid, Medicare or Children's Health Insurance Program), sex (including sex at birth or legal sex), sex characteristics (including intersex traits), pregnancy or related conditions, sex stereotypes, sexual orientation, gender identity or expression, veteran status, or any other category protected by law.

As a sponsored ministry of the Catholic Church, we provide health care services guided by the moral principles described in the Ethical and Religious Directives for Catholic Healthcare Services published by the U.S. Conference of Catholic Bishops.

Trinity Health Plan of Michigan provides free auxiliary aids and communication services, so that people can communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language isn't English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact

Language Assistance Services at 1-800-240-3851
Telecommunications Relay Service (TRS): 7-1-1

Trinity Health Plan of Michigan allows service animals that are trained to do work or perform tasks for the benefit of people with a disability.

If you need another type of reasonable modification or accessibility services, please discuss it with your provider or the Section 1557/Americans with Disabilities Act Coordinator:

Chapter 9 Legal notices

ATTN: Member Services Manager

3100 Easton Square Place, Suite 300
Columbus, OH 43219

Phone:

1-800-240-3851 (TTY: 711)

Fax:

1-833-802-2200

Email:

medigoldappeals@mchs.com

If you believe that Trinity Health Plan of Michigan has failed to provide these services or discriminated in another way, you can file a grievance with:

Member Services

3100 Easton Square Place Suite 300
Columbus, OH 43219

1-800-240-3851

medigoldappeals@mchs.com

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

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

800-368-1019, 800-537-7697 (TDD)

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

This notice is available on the Trinity Health Plan of Michigan website:
www.thpmedicare.org/michigan/.

Notice of Accessibility

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-240-3851 (TTY: 711) or speak to your provider.

Spanish: Español

ATENCIÓN: Si habla español, dispone de servicios gratuitos de asistencia lingüística. También dispone de recursos y servicios auxiliares gratuitos para proporcionar información en formatos accesibles. Llame al 1-800-240-3851 (TTY: 711) o hable con su proveedor.

Simplified Chinese: 中文

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-240-3851（文本电话：711）或咨询您的服务提供商。

Vietnamese: Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-240-3851 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Albanian: SHQIP

VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-240-3851 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Korean: 한국어

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-240-3851 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Bengali: বাংলা

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-240-3851 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Polish: POLSKI

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-240-3851 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Chapter 9 Legal notices

Ukranian: українська мова

УВАГА: Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-240-3851 (TTY: 711) або зверніться до свого постачальника».

Romanian: România

ATENȚIE: Dacă vorbiți România, aveți la dispoziție servicii gratuite de asistență lingvistică. De asemenea, sunt disponibile gratuit materiale auxiliare și servicii adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-240-3851 (TTY: 711) sau discutați cu furnizorul dumneavoastră.

Laotian: ວາວ

ເຊີນລາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-240-3851 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Hindi: हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-240-3851 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Thai: ไทย

หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-240-3851 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

Karen: ထာနီလီဖဲအံ

ဆူ- နမ့်ကတိ၊ ထာန့်လီဖအံ၊ အယိ၊ တ်အိဉ်ဒီး ကျိတ်တံဆိဉ်ထွဲမၤစၢၤ လၢတလၢ် ဉူဉ်လၢ်စ့ၤလၢနဂီၢ်လီၤ.
 တ်အိဉ်ဒီး တ်မၤစၢၤတၢ်န့ၢ်ဟူပီးလီၤဒီး တ်မၤစၢၤတၢ်မၤ လၢအ ကြးအဘဉ် လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤ
 လၢတၢ်မၤန့ၢ်အီၤသ့တဖၣ် လၢတလၢ်ဉူဉ်လၢ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-800-240-3851 (TTY: 711) မ့တမ့ၢ်
 ကတိတၢ်ဒီး နပုၤလၢဟ့ၣ် နတၢ်က့ၢ်ထွဲမၤစၢၤတက့ၢ်.

Somali: Soomaali

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luqadda bilaashka ah ayaa diyaar kuu ah. Kaalmooyinka iyo adeegyada ku habboon ee lagu bixiyo macluumaadka qaabab la heli karo ayaa sidoo kale lagu heli karaa lacag la'aan. Wac 1-800-240-3851 (TTY: 711) ama la hadal adeeg bixiyahaaga.

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, Trinity Health Plan of Michigan Glory No RX (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

CHAPTER 10:

Definitions

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Trinity Health Plan of Michigan Glory No RX (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period starts the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't 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 starts. There is no limit to the number of benefit periods.

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

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

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

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

Chapter 10 Definitions

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

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

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

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

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people 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 person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Chapter 10 Definitions

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

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

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

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

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

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

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

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

Hospital Inpatient Stay – A hospital stay when you’ve 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*.

Chapter 10 Definitions

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

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

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

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

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

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C- a plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Trinity Health Plan of Michigan Glory No RX (HMO) doesn’t offer Medicare prescription drug coverage.

Chapter 10 Definitions

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

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

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

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

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

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

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

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

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

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

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Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

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

Part B Rebatable Drug – Under the Medicare Prescription Drug Inflation Rebate Program, drug manufacturers must pay a rebate to Medicare if they increase the price of certain drugs faster than the rate of inflation. For drugs with price increases above inflation, the coinsurance will be based on 20% of the lower, inflation-adjusted price.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Chapter 10 Definitions

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

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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 based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

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

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

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation, care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

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

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

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

Chapter 10 Definitions

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

Trinity Health Plan of Michigan Glory No RX (HMO) Member Services

Method	Member Services – Contact Information
Call	1-800-240-3851 Calls to this number are free. 8 a.m. to 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. 8 a.m. to 8 p.m., 7 days a week
Fax	1-833-256-2871
Write	Trinity Health Plan of Michigan Attn: Member Services 3100 Easton Square Place Suite 300 Columbus, OH 43219
Website	www.thpmedicare.org/michigan/

Michigan Medicare Assistance Program (MMAP, Inc.) (Michigan SHIP)

Michigan Medicare Assistance Program (MMAP, Inc.) 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	1-800-803-7174
Write	MMAP, Inc. 6015 W. Saint Joseph Highway Suite 103 Lansing, MI 48917
Website	https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program

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