2027 Evidence of Coverage for MercyOne Health Plan Glory No RX (HMO)

Health Plan

OMB Approval 0938-1051 (Expires: July 31, 2029)

January 1 – December 31, 2027

Evidence of Coverage for 2027:

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

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your 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, MercyOne Health Plan Glory No RX (HMO), is offered by Mount Carmel Health Plan, Inc. (MercyOne Health Plan). (When this *Evidence of Coverage* says "we," "us," or "our," it means Mount Carmel Health Plan, Inc. (MercyOne Health Plan). When it says "plan" or "our plan," it means MercyOne Health Plan Glory No RX (HMO).)

This information is available in large print or audio.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

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

Y0164_EOCIAGloryNoRx27_M PRJ-11314

OMB Approval 0938-1051 (Expires: July 31, 2029)

Table of Contents

CHAPTER 1: Get started as a member 4

SECTION 1 You're a member of MercyOne Health Plan Glory No RX (HMO) 4
SECTION 2 Plan eligibility requirements 5
SECTION 3 Important membership materials 6
SECTION 4 Summary of Important Costs for 2027 7
SECTION 5 More information about your monthly plan premium 8
SECTION 6 Keep your plan membership record up to date 9
SECTION 7 How other insurance works with our plan 9

CHAPTER 2: Phone numbers and resources 11

SECTION 1 MercyOne Health Plan Glory No RX (HMO) contacts 11
SECTION 2 Get help from Medicare 14
SECTION 3 State Health Insurance Assistance Program (SHIP) 15
SECTION 4 Quality Improvement Organization (QIO) 16
SECTION 5 Social Security 17
SECTION 6 Medicaid 18
SECTION 7 Railroad Retirement Board (RRB) 19
SECTION 8 If you have group insurance or other health insurance from an employer 20

CHAPTER 3: Using our plan for your medical services 21

SECTION 1 How to get medical care as a member of our plan 21
SECTION 2 Use providers in our plan's network to get medical care 23
SECTION 3 How to get services in an emergency, disaster, or urgent need for care 26
SECTION 4 What if you're billed directly for the full cost of covered services? 29
SECTION 5 Medical services in a clinical research study 29
SECTION 6 Rules for getting care in a religious non-medical health care institution 31
SECTION 7 Rules for ownership of durable medical equipment 32

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay) 34

SECTION 1 Understanding your out-of-pocket costs for covered services 34
SECTION 2 The Medical Benefits Chart shows your medical benefits and costs 36

SECTION 3 Services that aren't covered by our plan (exclusions) 98

CHAPTER 5: Asking us to pay our share of a bill for covered medical services 101

SECTION 1 Situations when you should ask us to pay our share for covered services 101

SECTION 2 How to ask us to pay you back or pay a bill you got 103

SECTION 3 We'll consider your request for payment and say yes or no 103

CHAPTER 6: Your rights and responsibilities 104

SECTION 1 Our plan must honor your rights and cultural sensitivities 104

SECTION 2 Your responsibilities as a member of our plan 116

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints) 118

SECTION 1 What to do if you have a problem or concern 118

SECTION 2 Where to get more information and personalized help 118

SECTION 3 Which process to use for your problem 119

SECTION 4 A guide to coverage decisions and appeals 119

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal 123

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon 131

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon 135

SECTION 8 Taking your appeal to Levels 3, 4, and 5 139

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns 141

CHAPTER 8: Ending membership in our plan 146

SECTION 1 Ending your membership in our plan 146

SECTION 2 When can you end your membership in our plan? 146

SECTION 3 How to end your membership in our plan 148

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan 149

SECTION 5 MercyOne Health Plan Glory No RX (HMO) must end your plan membership in certain situations 149

CHAPTER 9: Legal notices 152

SECTION 1 Notice about governing law 152

SECTION 2 Notice about nondiscrimination 152

SECTION 3 Notice about Medicare Secondary Payer subrogation rights 154

CHAPTER 10: Definitions 157

CHAPTER 1:
Get started as a member

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

Section 1.1 You're enrolled in MercyOne Health Plan Glory No RX (HMO), which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, MercyOne Health Plan 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.

MercyOne Health Plan 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. MercyOne Health Plan Glory No RX (HMO) *doesn't* include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MercyOne Health Plan 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 MercyOne Health Plan Glory No RX (HMO) between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of MercyOne Health Plan Glory No RX (HMO) after December 31, 2027. We can also choose to stop offering our plan in your service area after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve MercyOne Health Plan 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 national, or an eligible noncitizen.

Section 2.2 Plan service area for MercyOne Health Plan Glory No RX (HMO)

MercyOne Health Plan 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 Iowa: Adair, Adams, Appanoose, Benton, Black Hawk, Boone, Bremer, Buchanan, Butler, Cedar, Cerro Gordo, Chickasaw, Clarke, Clayton, Clinton, Dallas, Decatur, Delaware, Fayette, Floyd, Franklin, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Henry, Humboldt, Iowa, Jackson, Jasper, Jefferson, Jones, Keokuk, Kossuth, Louisa, Lucas, Madison, Mahaska, Marion, Marshall, Mitchell, Monroe, Muscatine, Polk, Poweshiek, Ringgold, Scott, Tama, Union, Warren, Washington, Wayne, Winnebago, Worth and Wright

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 national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify MercyOne Health Plan Glory No RX (HMO) if you're not eligible to stay a member of our plan on this basis. MercyOne Health Plan Glory No RX (HMO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. 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 MercyOne Health Plan 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* (www.thpmedicare.org/mercyone/find-a-provider) lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

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 MercyOne Health Plan Glory No RX (HMO) authorizes use of out-of-network providers.

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 for 2027

	Your Costs in 2027
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 most 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	$25 copay per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	$375 copay per day for days 1-6; $0 copay per day for days 7-90

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

You don't pay a separate monthly plan premium for MercyOne Health Plan 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 2027* handbook in the section called *2027 Medicare Costs.* Download a copy from the Medicare website (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

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, MercyOne Health Plan 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 may be credited to your Social Security check or credited on your Medicare Part B premium statement.

Section 4.3 Optional Supplemental Benefit Premium

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 $16 for the Silver Premium Supplemental Plan or $36 for the Gold Premium Supplemental Plan.

SECTION 5 More information about your monthly plan premium

Section 5.1 Your monthly plan premium won't change during the year

We're not allowed to change your 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 your 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/Medical Group/IPA.

The doctors, hospitals, and other providers in your 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 about any other medical or drug coverage you have so we can coordinate any other coverage 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 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)
- 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 MercyOne Health Plan Glory No RX (HMO) contacts

For help with claims, billing, or member card questions, call or write to MercyOne Health Plan Glory No RX (HMO) Member Services. 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 1-800-240-3851 (TTY users call 711) 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	MercyOne Health Plan Attn: Member Services 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213
Website	www.thpmedicare.org/mercyone/

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 expediated 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: MercyOne Health Plan Attn: Health Services (Coverage Decisions) 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213 Appeals: MercyOne Health Plan Attn: Appeals and Grievances Department (Appeals) 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213

Coverage Decisions and Appeals for Medical Care – Contact Information	
Website	www.thpmedicare.org/mercyone/for-members/appeals-and-grievances (coverage decisions) www.thpmedicare.org/mercyone/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 **Expedited grievances:**
Write	MercyOne Health Plan Attn: Appeals and Grievances Coordinator 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213
Medicare website	To submit a complaint about MercyOne Health Plan Glory No RX (HMO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

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	MercyOne Health Plan Attn: Member Services 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213
Website	www.thpmedicare.org/mercyone/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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	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.
Website (continued)	You can also visit Medicare.gov to tell Medicare about any complaints you have about MercyOne Health Plan Glory No RX (HMO). **To submit a complaint to Medicare,** go to 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 Iowa, the SHIP is called Iowa Senior Health Insurance Information Program/Senior Medicare Patrol.

Iowa Senior Health Insurance Information Program/Senior Medicare Patrol is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Iowa Senior Health Insurance Information Program/Senior Medicare Patrol counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Iowa Senior Health Insurance Information Program/Senior Medicare Patrol counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Iowa Senior Health Insurance Information Program/Senior Medicare Patrol – Contact Information	
Call	1-800-351-4664
TTY	1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Iowa SHIIP and SMP 1963 Bell Avenue Suite 100 Des Moines, Iowa 50315 shiip@iid.iowa.gov
Website	https://shiip.iowa.gov/

SECTION 4 Quality Improvement Organization (QIO)

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

Commence Health has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. 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 is ending too soon.

Commence Health (Iowa's Quality Improvement Organization) – Contact Information	
Call	1-888-755-5580 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 23454
Website	https://www.commencehealthqio.cms.gov/en/contact-information

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 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

Social Security – Contact Information	
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 am to 7 pm, Monday through Friday.
Website	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 Medicare Savings Programs, contact Iowa Department of Medicaid.

Iowa Department of Medicaid – Contact Information	
Call	1-800-338-8366; hours: Available Monday – Friday, 8 a.m. to 5 p.m.
TTY	800-735-2942 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

Iowa Department of Medicaid – Contact Information	
Write	Iowa Medicaid Member Services 1305 East Walnut St. Des Moines, IA 50319-0114
Website	https://hhs.iowa.gov/

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 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.

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 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm 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 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

- **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, MercyOne Health Plan Glory No RX (HMO) must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

MercyOne Health Plan 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).
    - 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 you have to pay the provider in full for services you get. *Here are 3 exceptions:*
    - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
    - 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. Authorization should be obtained from the plan prior to seeking care. 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.
    - Our plan covers kidney dialysis services 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 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-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, your 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

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 our plan, you DON'T need a referral from him or her before seeking care from your other in-network providers. You may visit any network provider for covered services. However, your PCP is often the best person to help you find a specialist or other provider to meet your needs. Ask your PCP to help you; s/he is happy to do so.

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

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

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

How to choose a PCP?

You may select your PCP by using the MercyOne Health Plan Provider/Pharmacy Directory or by getting help from Member Services. You can also access a list of PCPs online www.thpmedicare.org/mercyone/find-a-providerat .

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.

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

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

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. 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 may 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 we approve a supply or service that requires prior authorization, the approval will specify what service has been approved, who can provide it and any limitations that may apply. If a prior authorization request is denied, you or the requesting provider may ask for an appeal (see Chapter 9, Section 5 for more information about filing an appeal). If you have questions about a particular approval notice (or denial), please call the Prior Authorization number on the back of your ID card.

When a specialist or another network provider leaves our plan

We may 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.

  - 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. Please refer to Chapter 9, Section 5 for further information about requesting coverage 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 9).

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:

- MercyOne Health Plan 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 isn't 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.

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

Your doctor may 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). MercyOne Health Plan 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 may 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 may request an expedited review. For details related to what qualifies for an expedited request, please refer to Chapter 9, 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, call Member Services at the number listed on the back cover of this document.

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

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 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're 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 2 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

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 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.

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

If you have an urgent need for services as described above and find that participating providers aren't reasonably accessible, you may 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 may be). Whether traveling or at home, contact Member Services if you need help locating an urgent care provider or advice on how to cost-effectively use your urgent care benefits.

Our plan covers worldwide emergency and urgent care.

Section 3.3 Get care during a disaster

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

Visit https://www.medicare.gov/providers-services/disaster-emergency for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our 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?

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

MercyOne Health Plan 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 that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you 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

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 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

exemption device (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

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 Medicare.gov/coverage/clinical-research-studies. 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 is **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.

MercyOne Health Plan 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

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 MercyOne Health Plan 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 some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at 1-800-240-3851 (TTY users call 711) 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

If you qualify for Medicare oxygen equipment coverage, MercyOne Health Plan 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 MercyOne Health Plan Glory No RX (HMO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our 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 applicable cost sharing 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 coinsurance 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 MercyOne Health Plan Glory No RX (HMO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

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

- **Copayment:** the 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 tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart 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's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $6,500.**

The amounts you pay for copayments and coinsurance 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 an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of

$6,500, you won't 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

As a member of MercyOne Health Plan 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 MercyOne Health Plan 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 emergency or urgent care, or unless our plan or a network provider gave you a referral. 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 from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. These services not listed in the Medical Benefits Chart also require prior authorization: Please refer to the plan website 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 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.

Inpatient Rehab

Long-Term Acute Care Hospital

Non-Medicare-covered Acupuncture – required for visits exceeding the annual visit limitation.

Oncology – Treatment Plans and Related Drugs

Out-of-Network Care (for HMO members)

Prosthetic devices and related supplies – you or your provider must get an approval from our plan before Trinity Health Plan New York will pay for devices or supplies greater than the Medicare-allowable amount.

Skin Substitutes and Biologics

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, go to your *Medicare & You 2027* handbook. View it online at 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're also 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 2027, 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.** **Virtual care visits** The virtual care visit combines a traditional nurse advice line with virtual physician consultations. Registered nurses provide the initial triage for symptoms any time of day or night, and provide a recommendation for care. Some situations qualify for additional consultations, in which case the nurse will connect the member with a virtual partner whose physicians will address the member's symptoms. Call 1-855-638-5842, 24 hours a day, 7 days a week for assistance.	$0 copay for visits using web/phone-based technologies. $0 copay for visits using the nurse hotline benefit. $0 copay for virtual care visits.
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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	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 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 • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may 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.	$20 copay for each Medicare-covered visit.

Covered Service	What you pay
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/mercyone/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.**
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.	$250 copay for each Medicare-covered ground ambulance service. $300 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.

Covered Service	What you pay
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 may 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 *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit. If lab, diagnostic or therapeutic services are provided during the same visit, a copay or coinsurance can apply. **Note:** Complete an Annual Wellness Visit (AWV) and submit the required attestation to receive a $50 reward loaded onto your Member Rewards Card. The previous Flexible Benefit Card is being renamed the Member Rewards Card, so please keep your current card if you are a returning member. In 2027, it will be used exclusively for Member Rewards. If you are a new member in 2027, you will receive $50 loaded on to a Member Rewards Card when you complete your AWV and complete the necessary attestation.

Covered Service	What you pay
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.

Covered Service	What you pay
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 covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$20 copay for each Medicare-covered cardiac rehabilitation services visit. $20 copay for each Medicare-covered intensive cardiac rehabilitation services visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Covered Service	What you pay
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 is covered once every 5 years (60 months).
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	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.	$15 copay for each Medicare-covered chiropractic visit.

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, coverage of 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 got 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. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	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 (continued) • 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.	$25 copay for Medicare-covered dental services.
In addition, we cover:	
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
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.** **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. 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. **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.	$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
When seeking dental care, we suggest you or your dentist send a dental treatment plan to be reviewed ahead of time so you can get an estimate for services. The pretreatment plan should include: 1. A list of services you will receive, using American Dental Association terminology and codes. 2. Your dentist's written description of the proposed treatment. 3. X-rays that show your dental needs. 4. Itemized cost of the proposed treatment. Please refer to our plan website www.thpmedicare.org/mercyone/ and click on the Plan & Benefits tab, then click on Discover Member Extras, and find the Dental section to search dental codes.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of 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 may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may 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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting. • Diabetes self-management training under certain conditions. Diabetic supplies and services are limited to certain manufacturers. The following formulary diabetic supplies are available: Meters/Test strips: Accu-check and True Metrix Continuous Glucose Monitors/Sensors: Freestyle Libre and Dexcom *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. 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 $0 copay for Medicare-covered diabetic monitors. $0 copay for Medicare-covered diabetic monitoring supplies. 20% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services. Diabetic testing supplies can be obtained at any of our in-network retail pharmacies nationwide or through our mail-order pharmacy, CVS Caremark.

Covered Service	What you pay
	Refer to Provider/Pharmacy directory for full list.
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. The most recent list of suppliers is available on our website at www.thpmedicare.org/mercyone/ *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 won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in MercyOne Health Plan Glory No RX (HMO), your cost sharing in MercyOne Health Plan Glory No RX (HMO) is 20% coinsurance.
EKG following the "Welcome to Medicare" visit Medicare covers a routine EKG or ECG screening if you get an order from your doctor or other health care provider during your one-time "Welcome to Medicare" preventive visit.	$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 • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that'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. • One Fitness Kit allowed per year, options include Fit Kit, Yoga Kit, or Dance Kit. • 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, physical fitness, and fitness equipment or kit. You must use One Pass® to access this benefit.

Covered Service	What you pay
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Hearing Exam: 1 routine hearing exam per year.** Fitting and evaluation for hearing aids: unlimited visits every year** Prescription 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 1-833-312-1237 (for TTY, dial 711) to schedule an appointment. 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.	$25 copay for each Medicare-covered exam to diagnose and treat hearing and balance issues. $0 copay for routine hearing exam (up to one per calendar year).** $0 copay for first year of follow-up visits for hearing aid fitting and adjustments.** $399 to $699 copay for one TruHearing Advance hearing aid and one TruHearing Premium hearing aid (respectively).** $50 additional cost per aid for optional hearing aid rechargeability.** **Please note**: The Flexible Benefit Card allowance previously used to supplement Vision and Hearing costs is not available in 2027. Keep your card in 2027 for Member Rewards (see Annual Wellness Visit for more information).

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 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 ***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. **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	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 MercyOne Health Plan 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
Hospice care (continued) • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by MercyOne Health Plan Glory No RX (HMO) but not covered by Medicare Part A or B:** MercyOne Health Plan 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.	
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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you 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.

Covered Service	What you pay
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 are 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: $375 copay per day for days 1-6; $0 copay per day for days 7-90 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 may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MercyOne Health Plan 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 outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at 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 authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd 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 receive 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: $375 copay per day for days 1-6; $0 copay per day for days 7-90 If you get authorized inpatient care from an out-of-network hospital after your emergency condition is stabilized, your cost is the cost you would pay at a network hospital.

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 *Physician/Practitioner Services, Including Doctor's Office Visits* row. **Diagnostic and radiological services, surgical dressings, and splints** See *Outpatient Diagnostic Tests and Therapeutic Services and Supplies* row. **Prosthetics, orthotics, and outpatient medical/ therapeutic supplies** See *Prosthetic and Orthotic Devices and Related Supplies* row. **Physical, speech, and occupational therapy services**

Covered Service	What you pay
	See *Outpatient Rehabilitation Services* row.
Meal 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.
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 may 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.

Covered Service	What you pay
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 sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
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 get 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) is administered intravenously. In addition to medication costs, you may 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 may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	For certain Part B drugs, you may be required to try a different drug first. $35 copay for Medicare Part B insulin drugs. Cost sharing for a one-month's supply is limited to $35. Service category and plan level deductibles do not apply. 20% of the total cost for Medicare Part B chemotherapy and radiation drugs.*** 20% of the total cost for other Medicare Part B drugs.***

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 may be subject to Step Therapy: www.thpmedicare.org/mercyone/for-providers/provider-administrative-manual/utilization-management/part-b-drug-requirements. We also cover some vaccines under our Part B drug benefit. *Prior authorization rules may 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 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	$20 copay for Medicare-covered opioid treatment services.
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.	**Outpatient X-rays** $0 copay for Medicare-covered services. **Therapeutic radiology services** 20% of the total cost 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.

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies* (continued) • 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.	**Diagnostic tests and procedures** $20 copay for Medicare-covered services. **Diagnostic radiology services** $200 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 in addition to coinsurance, if applicable.

Covered Service	What you pay
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 aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at 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.	$340 copay per stay for Medicare-covered outpatient hospital observation services.

Covered Service	What you pay
Outpatient hospital services*	$325 copay per visit for surgery performed in an ambulatory surgical center (ASC) or in an outpatient hospital facility.
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 you can't give yourself	$0 copay for lab tests. $0 copay for X-ray services. $200 copay for diagnostic radiological PET scan services. $200 copay for all other diagnostic radiological services other than PET scan services.
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 aren't sure if you're an outpatient, ask the hospital staff. You can also find more information in a Medicare fact sheet called *Medicare Hospital Benefits*. 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.	20% of the total cost for therapeutic radiological services. 20% of the total cost for Part B drugs and biologicals when provided during an outpatient hospital service.***
***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.	$0 copay per visit to a Coumadin clinic. $25 copay per visit to a respiratory therapy department.

Covered Service	What you pay
	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 (CSW), clinical nurse specialist (CNS), 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.	$20 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. $20 copay for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist). $20 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).	$25 copay for each Medicare-covered occupational therapy visit. $25 copay for each Medicare-covered physical and/or speech therapy visit.
Outpatient substance use disorder services Coverage includes treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital 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.	$20 copay for each Medicare-covered individual therapy visit. $20 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 outpatient.	For Medicare-covered services at an ambulatory surgical center, you pay $325 copay. For Medicare-covered services at an outpatient hospital facility, you pay $325 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
	in addition to coinsurance, if applicable.
Over-the-counter allowance OTC items that are drug and health-related 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 may order in one of three simple ways: • Visit a participating CVS retail location. • Call 1-888-628-2770 (TTY 711), Monday to Friday, 9 a.m. – 8 p.m. • Visit our customized website at 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.	$50 maximum plan coverage amount every 3 months for OTC items. ** Unused portion does not carry over to the next period. Members are responsible for the difference if the total exceeds the quarterly allowance. The quarterly allowance may only be exceeded at the retail locations. Orders placed over the phone and online must total the quarterly allowance or less. You must use CVS Flex Benefits to access this benefit (formerly known as Over The Counter Health Solutions).

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get 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. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get 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.	$40 copay per day for Medicare-covered partial hospitalization services. $40 copay for Medicare-covered intensive outpatient program 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 specialist, if your doctor orders it to see if you need medical treatment ○ Certain telehealth services, including: those rendered by a PCP, specialist, mental health care provider, or psychiatrist. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Members should call their provider first to inquire if telehealth services are available before seeking treatment. ○ Telehealth services may 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. $25 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 $25 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. 20% of the total cost 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
• 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
	$25 copay for basic hearing and balance exam.
	
	$0 copay for X-rays (examples include but aren't limited to a basic film X-ray of an ankle, shoulder, or foot).
	
	$20 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.
	
	$200 copay for diagnostic radiological PET scan services.
	$200 copay for all other diagnostic radiological services other than PET scan services.
	$0 copay for lab tests.
	
	$25 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 responsible for the

Covered Service	What you pay
	highest copay for services in addition to coinsurance, if applicable.
Physician/practitioner services, including doctor's office visits* (continued) • 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. ***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.	
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	$25 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 including the fee for injecting the drug, if applicable • 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.
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.
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 *Vision Care* 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 Medicare-covered medical supplies related to prosthetic and orthotic devices.

Covered Service	What you pay
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.	$15 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.
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 cover 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.

Covered Service	What you pay
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an 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. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide 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.
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 are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
Services to treat kidney disease Kidney disease and dialysis 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 **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. $25 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 of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for 100 days per benefit period for Medicare-covered SNF stays. 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 our plan of care (this includes substances 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	Inpatient hospital stay is not required prior to admission. For Medicare-covered SNF stays, you pay: $0 copay per day for days 1-20; $221 copay per day for days 21-65; $0 copay per day for days 66-100 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
Skilled nursing facility (SNF) care (continued) Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but don't have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that can be affected by tobacco: 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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$15 copay for each Medicare-covered SET visit.

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, or, even if you're inside our plan's service area, it's 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 our plan's service area 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.

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** $25 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. **Please note**: The Flexible Benefit Card allowance previously used to supplement Vision and Hearing costs is not available in 2027. Keep your card in 2027 for Member Rewards (see Annual Wellness Visit for more information).
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.	$200 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 Iowa, but within the United States and its territories, members may see out-of-network providers for covered, medically necessary services and pay in-network cost sharing. • Members must contact Member Services at 1-800-240-3851, 8 a.m. - 8 p.m., 7 days a week prior to traveling to initiate the benefit. • If the benefit 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 may 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	$3,000 allowance towards visitor/travel covered, medically necessary services from out-of-network providers when traveling outside the state of Iowa. Amounts don't carry over from year to year.

Covered Service	What you pay
the service area; failure to notify our plan may 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 *Welcome to Medicare* 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 vaccines)), and referrals for other care if needed. **Important**: We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* 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. $250 to $300 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 may 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

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

Services that are covered for you	What you must pay when you get these services
Optional Dental Services** Members may separately purchase the Optional Supplemental Dental benefit. Our plan offers the Dental Silver benefit. The premium for the Dental Silver benefit is $16 per month. You pay this monthly premium in addition to your Medicare Part B premium and plan premium (if applicable). Covered services include: • Emergency palliative treatment – to temporarily relieve pain. • Radiographs – bitewing (twice per calendar year); full mouth X-rays, which include bitewings (once in any three-year period). • All other radiographs – other X-rays. • Diagnostic services. • Extractions – non-surgical removal of teeth. • Restorative services – fillings and crown repair. • Endodontic services – root canals. • Periodontic services – to treat gum disease. • Other oral surgery – dental surgery.	**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.

Optional Dental Important Information: 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 administered by Dental Benefit Providers, Inc.

When seeking dental care, we suggest you or your dentist send a dental treatment plan to be reviewed ahead of time so you can get an estimate for services. The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association terminology and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.

Please refer to our plan website www.thpmedicare.org/mercyone/ 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.

Services that are covered for you	What you must pay when you use these services
Optional Dental Services** Members may separately purchase the Optional Supplemental Dental benefit. Our plan offers the Dental Gold benefit. The premium for the Dental Gold benefit is $36 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.	**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.

Optional Dental Important Information: For more information or assistance finding a dental plan network provider near you, call you 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 administered by Dental Benefit Providers, Inc.

When seeking dental care, we suggest you or your dentist send a dental treatment plan to be reviewed ahead of time so you can get an estimate for services. The pretreatment plan should include:

1. A list of services you will receive, using American Dental Association terminology and codes.
2. Your dentist's written description of the proposed treatment.
3. X-rays that show your dental needs.
4. Itemized cost of the proposed treatment.

Please refer to our plan website www.thpmedicare.org/mercyone/ 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.

Enrolling in our Optional Supplemental Dental Plans

As a member of our plan, you may voluntarily choose to enroll in one of the Optional Supplemental Dental Plans. The premium for the Dental Silver Plan is $16 per month. The premium for the Dental Gold plan is $36 per month. You'll pay this amount in addition to your Medicare Part B premium and monthly plan premium (if applicable). New members may elect an Optional Supplemental Dental Plan at the time of their enrollment with coverage beginning when they become effective with 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 may 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 10. Please know that all premiums must be paid current (in full) before we can accept your request to purchase this Optional Supplemental Dental Plan.

If you get behind on your monthly premium payments, future payments will be applied first to the oldest outstanding balances you owe for your health plan premiums. Please keep your payments current to avoid unnecessary inconvenience and confusion. If you 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 your plan's optional visitor/traveler benefit

If you don't permanently move, but are continuously away from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program outside of Iowa but within the United States and its territories, which will allow you to stay 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. Contact our plan for help in locating a provider when using the visitor/traveler benefit.

This benefit has an annual coverage maximum of $3,000 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 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 may 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 may 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 you 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 made to not cover a medical service, go to Chapter 7, Section 5.3.)

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 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

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
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
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
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

Services not covered by Medicare	Covered only under specific conditions
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine 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 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:

MercyOne Health Plan
Attn: Member Services
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

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

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

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

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. We can also give you information 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 to 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 MercyOne Health Plan 1-800-240-3851 (TTY: 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 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 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 are 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.
    - 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 at 1-800-240-3851 (TTY users call 711).

Notice of Privacy Practices

Policy last revised February 16, 2026

Protection of Information

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

Permitted Uses and Disclosures

Treatment

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

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

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Payment

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

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

Health Care Operations

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

Other Uses and Disclosures

Information and Health Promotion Activities

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

Research

Under certain circumstances, Company may use and disclose your PHI for research purposes. Research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients’ need for privacy of their medical information. Researchers are required to safeguard all PHI they receive. We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects; however, with

very limited exceptions such disclosures must first be cleared through this special approval process.

More Stringent State and Federal Laws

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

The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.

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. For example, Ohio law may require that we obtain your authorization before releasing records containing HIV/AIDs diagnosis or before disclosing information regarding treatment you received at an Ohio licensed behavioral health facility. And in Idaho, electronic medical records must be provided by hospitals within three (3) days of the request being received.

Permitted Uses or Disclosures With an Opportunity for You to Agree or Object

Family/Friends

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

Other Permitted Uses and Disclosures

Company may also disclose your PHI as follows.

Administer Your Plan

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

Business Associates

To organizations that provide services to us and assure us in writing that they will protect the information. We will give out as little information as possible to allow our business associates to complete these tasks and Company requires these business associates to appropriately safeguard the privacy of your information.

Membership in Trinity Health

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

Uses and Disclosures Permitted by Public Policy or Law Without Your Authorization

Law Enforcement

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

Legal Proceedings

Company will use and disclose PHI in response to a court order or other lawful purpose.

Required by Law

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

Public Health Oversight or Safety

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

Health Information Exchange (HIE)

Your PHI may be disclosed to an approved health information exchange (“HIE”) to facilitate the provision of health care to you. The HIE has a duty under the law to maintain appropriate administrative, physical and technical safeguards to protect the privacy and security of PHI. Only authorized individuals may access and use PHI from the HIE. You or your personal representative have the right to request in writing that Company do either or both of the following: (i) not disclose any of your PHI to the HIE; and (ii) not disclose specific categories of your PHI to the HIE.

Any restrictions on the disclosure of PHI you request as described in the prior sentence may result in a health care provider not having access to information that is necessary for the provider to render appropriate care to you. Company will honor all requests for restrictions on disclosure of PHI to health information exchange(s) as required by law.

For more information or to request restrictions, please contact Company, either by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Phone

1-800-240-3851 (TTY/TDD 711)
8 a.m. to 8 p.m., seven days a week

Use or Disclosure Requiring Your Authorization

Marketing

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

Psychotherapy Notes, Sale of PHI, and Other Uses

In addition to marketing and research, the following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes (if recorded by a mental health professional); and (ii) disclosures that constitute a sale of PHI. Company does not share or sell your PHI to companies that market health care products or services directly

to consumers for use by those companies to contact you, such as drug companies, unless you have signed an authorization.

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

Individual Rights

Under federal privacy regulations, you have the following rights regarding your personal health information. You can exercise these rights as described below by contacting Company, either by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Member Services

1-800-240-3851 (TTY/TDD 711)
8 a.m. to 8 p.m., seven days a week

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

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

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

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

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

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

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Company. You may submit complaints directly to Company by mail or by calling Member Services.

Mail

5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

Member Services

1-800-240-3851 (TTY/TDD 711)
8 a.m. to 8 p.m., seven days a week

Company assures you that filing a complaint will in no way affect your covered services or membership in our plan – we will not retaliate against you for filing a complaint.

Complaints may also be filed with the Department of Health and Human Services, Office for Civil Rights, by:

- Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201,
- Calling 1-877-696-6775
- Visiting www.hhs.gov/ocr/privacy/hipaa/complaints

Further Information

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

Changes to This Notice

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

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

As a member of MercyOne Health Plan 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.
- **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's 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.
- **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 call 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 Iowa Department of Public Health.

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 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 1-800-351-4664. (TTY users call 1-800-735-2942)
- **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 1-800-351-4664. (TTY users call 1-800-735-2942)

- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections*. (available at: 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.
- **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* our plan service area, you can't stay 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. Iowa Senior Health Insurance Information Program/Senior Medicare Patrol: 1-800-351-4664 (TTY users call 1-800-735-2942) Monday – Friday, 8 a.m. to 4 p.m..

Medicare

You can also contact Medicare for help.

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

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 at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmedicare.org/mercyone/.)
    - 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 CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.thpmedicare.org/mercyone/.) This form gives that person permission to act on your behalf. It must be signed by you and by the person 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 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

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 which 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

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

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

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 usually 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 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

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 may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for 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 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. The independent review organization will notify you in writing when it gets your 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 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. The independent review organization will notify you in writing when it gets your 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. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

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**. If they take extra days, they will notify you in writing. 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**. If they take extra days, they will notify you in writing. 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 Levels 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

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have got 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 our share of 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.
   - 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 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

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 Assistance Program (SHIP) for personalized help. 1-800-351-4664 (TTY users call 1-800-735-2942). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. 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 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

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 their 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 it's 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

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

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. 1-800-351-4664 (TTY users call 1-800-735-2942). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and 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 their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it'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 their 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 Levels 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?

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?

Complaint	Example
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 *timeliness* 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 *fast coverage decision* or a *fast appeal*, 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

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's 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:

MercyOne Health Plan
ATTN: Appeals and Grievances Department
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

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

  - If you have a complaint about MercyOne Health Plan refusing to grant a request for an expedited organization determination or reconsideration request. In some instances, MercyOne Health Plan 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

You can submit a complaint about MercyOne Health Plan Glory No RX (HMO) directly to Medicare. To submit a complaint to Medicare, go to 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 MercyOne Health Plan 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 coverage:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - 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

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

In certain situations, members of MercyOne Health Plan 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 Medicare.gov.

- Usually, when you move.
- If you have 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 your plan.

Section 2.4 Get more information about when you can end your membership

If you have 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 2027*** 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 MercyOne Health Plan Glory No RX (HMO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from MercyOne Health Plan Glory No RX (HMO) when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare *without* a separate Medicare 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 call 1-877-486-2048. • You'll be disenrolled from MercyOne Health Plan 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 MercyOne Health Plan Glory No RX (HMO) must end your plan membership in certain situations

MercyOne Health Plan 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 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 national, or an eligible noncitizen
- 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 may have your case investigated by the Inspector General.

» If you don't pay your plan premiums for 90 days.

    - We must notify you in writing that you have 90 days to pay your 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 can't ask you to leave our plan for any health-related reason

MercyOne Health Plan 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

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 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

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.

MercyOne Health Plan 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.

MercyOne Health Plan 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
MercyOne Health Plan 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:
ATTN: Member Services Manager
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213

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

Fax:
1-833-802-2200

Email:
medigoldappeals@mchs.com

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

Member Services
5955 E. Broad Street
Health Plan - 2nd Floor
Columbus, OH 43213
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://hhs.gov/ocr/office/file/index.html
This notice is available on the MercyOne Health Plan website:
www.thpmedicare.org/mercyone/.

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, MercyOne Health Plan 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.

SECTION 4 Other notices

According to CMS regulations at 42 CFR sections 422.108 and 423.462, MercyOne Health Plan, 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. Out-of-network care is only considered when services are not accessible in-network (does not apply for PPO). Out-of-network or non-contracted providers are under no obligation to treat MercyOne Health Plan members, except in emergency situations. MercyOne Health Plan encourages members or their provider to contact Member Services for a pre-service organization determination before you receive a service. Please call Member Services at 800-240-3851 (TTY: 711) or see your Evidence of Coverage for more information, including cost-sharing that applies to out-of-network services. To file a grievance, call 800-240-3851 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week, or call 1-800-MEDICARE (TTY: 1-877-486-2048) to file a complaint with Medicare. You can also fax 833-802-2495 or write to: MercyOne Health Plan, (HMO), Attn: Appeals and Grievances Department, 5955 E Broad Street, Health Plan - Second Floor, Columbus OH 43213. One Pass® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. The One Pass program varies by plan/area. Equipment, classes, personalized fitness plans and events may vary by location. One Pass is not responsible for the services or information provided by third parties. Employers should consult an appropriate tax professional to determine if individuals have any tax obligations.

MercyOne Health Plan Glory No RX (HMO) is a HMO plan with a Medicare contract. Enrollment in plan(s) depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Out-of-network/non-contracted providers are under no obligation to treat MercyOne Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services. Health coverage is offered by Mount Carmel Health Plan, Inc..

MercyOne Health Plan is a Medicare Advantage organization with a Medicare contract. Enrollment in MercyOne Health Plan depends on contract renewal. Benefits vary by county. Other pharmacies, physicians or providers are available in the plan’s network. Speak with a licensed sales agent during call center hours: April 1 to September 7, 8 a.m. to 8 p.m., Monday through

Friday; September 8 to March 31, 8 a.m. to 8 p.m., seven days a week. To file a grievance, call 1-800-MEDICARE (TTY users call 1-877-486-2048) to file a complaint with Medicare. One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. MercyOne Health Plan is an affiliate of Trinity Health. In select counties, MercyOne Health Plan offers Medicare Advantage plans in partnership with Trinity Health's regional health ministry. Most operational and administrative functions for the plan are performed through the plan's headquarters in Columbus, Ohio. MercyOne Health Plan has the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer.

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 may 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 MercyOne Health Plan 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 begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

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

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

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

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

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

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

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.

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

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

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

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

Extra Help – A Medicare 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.

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 and 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**. MercyOne Health Plan Glory No RX (HMO) does not offer Medicare prescription drug coverage.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all 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**.

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.

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.

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

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 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 gotten 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 gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 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 may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who 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.

MercyOne Health Plan 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 at 1-800-240-3851 (TTY users call 711) 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	MercyOne Health Plan Attn: Member Services 5955 E. Broad Street Health Plan - 2nd Floor Columbus, OH 43213
Website	www.thpmedicare.org/mercyone/

Iowa Senior Health Insurance Information Program/Senior Medicare Patrol

Iowa Senior Health Insurance Information Program/Senior Medicare Patrol 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	1-800-351-4664
TTY	1-800-735-2942 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.
Write	Iowa SHIIP and SMP 1963 Bell Avenue Suite 100 Des Moines, Iowa 50315
Website	https://shiip.iowa.gov/

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.*

The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.