January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of MVP Medicare WellSelect with Part D (PPO)

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

For questions about this document, please contact the MVP Medicare Customer Care Center at 1-800-665-7924. (TTY users should call 711). Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.. This call is free.

This plan, MVP Medicare WellSelect with Part D (PPO), is offered by MVP Health Plan, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means MVP Health Plan, Inc. . When it says "plan" or "our plan," it means MVP Medicare WellSelect with Part D (PPO).)

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

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

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,

- Other protections required by Medicare law.

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2024 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in MVP Medicare WellSelect with Part D (PPO, which is a Medicare PPO

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

MVP Medicare WellSelect with Part D (PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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

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

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

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of MVP Medicare WellSelect with Part D (PPO). It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MVP Medicare

WellSelect with Part D (PPO) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in MVP Medicare WellSelect with Part D (PPO) between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of MVP Medicare WellSelect with Part D (PPO) after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for MVP Medicare WellSelect with Part D (PPO)

MVP Medicare WellSelect with Part D (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact the MVP Medicare Customer Care Center to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

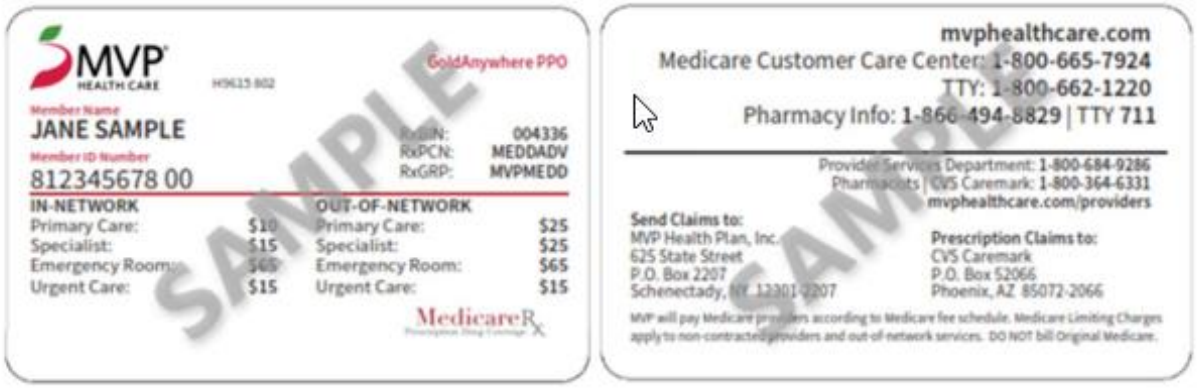
Section 2.3 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

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

Section 3.2 Provider Directory

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

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

The most recent list of providers and suppliers is also available on our website at **mvphealthcare.com**.

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

Section 3.3 Pharmacy Directory

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

If you don't have the *Pharmacy Directory*, you can get a copy from the MVP Medicare Customer Care Center. You can also find this information on our website at **mvphealthcare.com**.

Section 3.4 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in MVP Medicare WellSelect with Part D (PPO). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the MVP Medicare WellSelect with Part D (PPO) "Drug List."

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

We will provide you a copy of the "Drug List." The "Drug List" we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact the MVP Medicare Customer Care Center to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (**mvphealthcare.com**) or call the MVP Medicare Customer Care Center.

SECTION 4 Your monthly costs for MVP Medicare WellSelect with Part D (PPO)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for MVP Medicare WellSelect with Part D (PPO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

When you first enroll in MVP Medicare WellSelect with Part D (PPO), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

    - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
    - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year.: For 2023, this average premium amount was $32.74. This amount may change for 2024.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are 4 ways you can pay the penalty.

Option 1: Paying by check

You can choose to pay your monthly Part D late enrollment penalty by check or money order, directly to MVP. Payments should be mailed to the address on our billing statement. Checks should be made payable to MVP Health Care and must be received by the first day of the month. If your check is returned for insufficient funds, MVP will inform you in a letter and add a fee of $40.00 per occurrence to your balance due. If the problem continues to occur, MVP will request all future payments in the form of money orders or certified bank checks.

Option 2: You can pay using our Online Payment Center

You can choose to pay your monthly Part D late enrollment penalty by direct debit from your bank account, credit card, or debit card through our online Payment Center. You can make a one-time payment or set up recurring payments. To use the Payment Center, visit mvphealthcare.com and LOG IN to access your online account. If you are a first-time user, you will need to REGISTER for an online account. Select Payment Center under Your Plan to set up your payment preference and pay your bill. The recurring payment option will automatically debit your bank account or charge your credit card on the first business day of each month. The amount due for your recurring payment is based on your Part D late enrollment penalty owed as of the 29th of the month. If there is an issue with your account, such as insufficient funds, MVP will inform you in a letter and add a fee of $20 per occurrence to your balance due. If you receive a new credit or debit card, Log In to your MVP online account and update the card number and expiration date.

Option 3: You can pay by phone

You can make a one-time payment with your bank account, debit card or credit card using the secure, automated MVP Health Care Telephone Payment System. Call 1-844-712-6100 and follow the prompts. You will need your monthly premium invoice and your bank account, credit card or debit card information.

Option 4: Having your Part D late enrollment penalty taken out of your monthly Social Security check

Changing the way you pay your Part D late enrollment penalty. If you decide to change the option by which you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time. To change your payment method, you may call the MVP Medicare Customer Care Center to request a change. The phone number for the MVP Medicare Customer Care Center is on the back of this booklet.

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

Your Part D late enrollment penalty is due in our office by the 1st day of the month. If we have not received your payment by the 1st day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your Part D late enrollment penalty payment, if owed, within 90 days If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying yourPart D late enrollment penalty, if owed, on time, please contact the MVP Medicare Customer Care Center to see if we can direct you to programs that will help with your costs.

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

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

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty, if owed, within our grace period, you can

make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at **1-800-933-3920, ext. 48037** , Monday – Friday from 8 am to 4 pm Eastern Time. TTY users should call. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

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

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

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number

Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)

If you have any liability claims, such as claims from an automobile accident

If you have been admitted to a nursing home

If you receive care in an out-of-area or out-of-network hospital or emergency room

If your designated responsible party (such as a caregiver) changes

- If you are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

If any of this information changes, please let us know by calling the MVP Medicare Customer Care Center.

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its

coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

If you have retiree coverage, Medicare pays first.

If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.

If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

No-fault insurance (including automobile insurance)

Liability (including automobile insurance)

Black lung benefits

Workers' Compensation

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 MVP Medicare WellSelect with Part D (PPO) contacts (how to contact us, including how to reach the MVP Medicare Customer Care Center)

How to contact the MVP Medicare Customer Care Center

For assistance with claims, billing, or member card questions, please call or write to MVP Medicare WellSelect with Part D (PPO) the MVP Medicare Customer Care Center. We will be happy to help you.

Method	The MVP Medicare Customer Care Center – Contact Information
CALL	1-800-665-7924 Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.The MVP Medicare Customer Care Center also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
FAX	585-327-2298
WRITE	MVP Health Care – Medicare Customer Care Center 20 S. Clinton Ave Rochester, NY 14604
WEBSITE	mvphealthcare.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	1-800-665-7924 Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
FAX	585-327-2298
WRITE	MVP Health Care – Medicare Customer Care Center 20 S. Clinton Ave Rochester, NY 14604
WEBSITE	mvphealthcare.com

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

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-665-7924 Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
WRITE	MVP Health Care - Member Appeals Department PO Box 2207 625 State Street Schenectady, NY 12301
MEDICARE WEBSITE	You can submit a complaint about MVP Medicare WellSelect with Part D (PPO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

Method	Payment Requests – Part C Claims Contact Information
CALL	1-800-665-7924 Calls to this number are free. MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
TTY	Dial 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
WRITE	MVP Health Care PO Box 2207 625 State Street Schenectady, NY 12301
WEBSITE	mvphealthcare.com

Method	Payment Requests – Part D Claims Contact Information
CALL	1-866-494-8829 Calls to this number are free. CVS/Caremark Customer Service Hours are 24/7, 365 days per year.
TTY	Dial 711 Calls to this number are free. CVS/Caremark Customer Service Hours are 24/7, 365 days per year.
WRITE	CVS/Caremark PO Box 2110 Pittsburgh, PA 15230-2110
WEBSITE	mvphealthcare.com

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about MVP Medicare WellSelect with Part D (PPO) : • **Tell Medicare about your complaint:** You can submit a complaint about MVP Medicare WellSelect with Part D (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

> If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

- The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:
- In New York, the SHIP is called Health Insurance Information Counseling and Assistance Program (HIICAP).

HIICAP is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HIICAP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES

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

Method	**Health Insurance Information Counseling and Assistance Program (HIICAP) (New York SHIP) – Contact Information**
CALL	1-800-701-0501
WRITE	You may call the number above to find the address for your local HIICAP counselor.
WEBSITE	www.aging.ny.gov

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state.

- For New York, the Quality Improvement Organization is called Livanta BFCC-QIO.

Livanta BFCC-QIO has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta BFCC-QIO is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO in any of these situations:

You have a complaint about the quality of care you have received.

You think coverage for your hospital stay is ending too soon.

You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta BFCC-QIO, Region 2 – (New York's Quality Improvement Organization) – Contact Information
CALL	1-866-815-5440 Monday-Friday: 9:00 am - 5:00 pm 24-hour voicemail service is available
TTY	1-866-868-2289 Monday-Friday: 9:00 am - 5:00 pm This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	livantaqio.com/en

SECTION 5 Social Security

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

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

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

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

SECTION 6 Medicaid

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

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

Qualifying Individual (QI): Helps pay Part B premiums.

Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact New York State Medicaid or Green Mountain Care.

Method	New York State Medicaid – Contact Information – Contact Information
CALL	1-800-541-2831
WRITE	New York State DOH Corning Tower Empire State Plaza Albany, NY 12237
WEBSITE	www.health.ny.gov/health_care/31edicaid/

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

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

Medicare's "Extra Help" Program

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

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

1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;

The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or

Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

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

- Send a letter to MVP Health Care, MVP Medicare Customer Care Center, 20 S. Clinton Ave Rochester, NY 14604 describing why you believe you qualify for Extra Help. Please include any letters you received.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact the MVP Medicare Customer Care Center if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

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

- In New York, the AIDS Drug Assistance Program (ADAP) is the New York State Department of Health HIV Uninsured Care Program.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call New York State Department of Health HIV Uninsured Care Program at 1-800-542-2437.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- In New York, the State Pharmaceutical Assistance Program is the Elderly Pharmaceutical Insurance Program (EPIC).

Method	EPIC (New York's State Pharmaceutical Assistance Program)– Contact Information
CALL	1-800-332-3742 Monday – Friday: 8:30 am to 5 pm Eastern Time
TTY	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	EPIC P.O. Box 15018 Albany, NY 12212-5018
WEBSITE	www.health.state.ny.us/health_care/epic

SECTION 8 How to contact the Railroad Retirement Board

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

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

SECTION 9 Do you have group insurance or other health insurance from an employer?

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

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

CHAPTER 3:
Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

Providers are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.

Covered services include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, MVP Medicare WellSelect with Part D (PPO)must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

MVP Medicare WellSelect with Part D (PPO)will generally cover your medical care as long as:

The care you receive is included in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this document).

The care you receive is considered medically necessary. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

You receive your care from a provider who is eligible to provide services under Original Medicare. As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

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

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

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

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

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

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

When you become a member of our Plan, you may choose a plan provider to be your PCP. Your PCP is a physician or a health care professional who meets state requirements and is trained to give you basic medical care. You will get your routine or basic care from your PCP. Providers specializing in family practice, internal medicine, general practice, geriatric medicine and OB/GYN may all act as PCPs.

The role of your PCP includes managing your overall health care. Your PCP does this by seeing you on a regular basis and coordinating the use of specialists. Your PCP will also help you plan continued health care services following a hospitalization, surgery, emergencies, urgent care, and other services that require follow up care.

Your PCP will provide most of your care including routine and preventive services. Your PCP will also coordinate other services you get, including referrals to other specialists as needed, requesting additional tests and procedures as needed, and monitoring the care you receive from other providers. Your PCP should be aware of all care you receive in order to help you make well-informed decisions about your health care. This includes inpatient hospitalizations, outpatient procedures, and specialist visits. In some cases, your PCP will need to get prior authorization (prior approval) from us before certain treatment and procedures are covered.

How do you choose your PCP?

Choose your PCP by using the MVP Provider Directory or getting help from the MVP Medicare Customer Care Center. You may access the Provider Directory on our website at **mvphealthcare.com**. Once you know the name of a physician you would like to see, confirm that he or she is accepting new patients and then contact the MVP Medicare Customer Care Center with the name of your new PCP.

Changing your PCP

You may change your PCP for any reason at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan. You may choose a different PCP by using the Provider Directory or getting help from the MVP Medicare Customer Care Center. You may also access the Provider Directory on our website at **mvphealthcare.com**. Once you know the name of a physician you would like to see, confirm that he or she is accepting new patients and then contact the MVP Medicare Customer Care Center with the name of your new PCP. Your new PCP will be effective immediately.

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers.

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

  Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher. If possible, please let us know before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- Specialist office visits.
- Chiropractic care.

Section 2.3 How to get care from specialists and other network providers

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

Oncologists care for patients with cancer.

Cardiologists care for patients with heart conditions.

Orthopedists care for patients with certain bone, joint, or muscle conditions.

You do NOT need a referral from your PCP to see a specialist in our provider network.

Prior authorization may be needed for certain services (please see Chapter 4 or information which services require prior authorization). Authorization can be obtained from the plan. You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information

about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

If you do not have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization may be required.
- If you find out that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Section 2.4 How to get care from out-of-network providers

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

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

You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services*

or drugs) for information about what to do if you receive a bill or if you need to ask for reimbursement.

If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network

  As soon as possible, make sure that our plan has been told about your emergency. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The MVP Medicare Customer Care Center phone numbers are on the back of your ID card.

What is covered if you have a medical emergency?

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

emergency.

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

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

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

What if it wasn't a medical emergency?

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

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

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

What are urgently needed services?

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

You can find a list of urgent care centers in our network by using the *Provider Directory* or getting help from the MVP Medicare Customer Care Center. You may also access the *Provider Directory* on our website at **mvphealthcare.com**.

Our plan covers worldwide emergency and urgent care outside the United States under the same circumstances as emergency and urgent care within the United States. For more information about emergency and urgent care, please refer to the Medicare Benefits Chart in Chapter 4 of this booklet. Our plan does NOT cover any non-urgent or non-emergency services outside the United States.

Section 3.3 Getting care during a disaster

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

Please visit the following website: In New York, www.health.ny.gov/environmental/emergency/ for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

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

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

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

MVP Medicare WellSelect with Part D (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These services will not count toward the out-of-pocket maximum on medical services. You can call the MVP Medicare Customer Care Center when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a clinical research study?

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

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

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

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

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

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

Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.

Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

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

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

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

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

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

The facility providing the care must be certified by Medicare.

Our plan's coverage of services you receive is limited to non-religious aspects of care.

If you get services from this institution that are provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
- – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Please see the benefits chart in Chapter 4 for more information on Inpatient Hospital or Skilled Nursing Facility coverage.

SECTION 7 Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage MVP Medicare WellSelect with Part D (PPO) will cover:

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

If you leave MVP Medicare WellSelect with Part D (PPO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what is covered and what you pay)

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

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

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

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

Copayment is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)

Coinsurance is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

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

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

> Your **in-network maximum out-of-pocket amount** is $7,550. This is the most you pay during the calendar year for covered Medicare Part A and Part B *OR* plan services received from network providers. The amounts you pay for copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs, and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-

network maximum out-of-pocket amount. These services are described in the Medical Benefits Chart.) If you have paid $7,550 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Your **combined maximum out-of-pocket amount** is $11,300. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are described in the Medical Benefits Chart.) If you have paid $11,300 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the in-network and combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.2 above), we also have a separate maximum out-of-pocket amount that applies only to certain types of services.

The plan has a maximum out-of-pocket amount the following types of services:

- Our maximum out-of-pocket amount for an inpatient hospital admission is $1,925. Once you have paid $385 per day for the first 5 days (a total of $1,925) for an inpatient hospital admission, the plan will cover these services at no cost to you for the rest of your inpatient stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for inpatient hospital admissions apply to your covered inpatient hospital admission. This means that once you have paid either $7,550 for Part A and Part B covered medical services or $1,925 for your inpatient hospital admission, the plan will cover your inpatient hospital admission at no cost to you for the rest of your hospital stay.

- Our maximum out-of-pocket amount for inpatient mental health is $1,850. Once you have paid $370 per day for the first 5 days (a total of $1,850) for inpatient mental health, the plan will cover these services at no cost to you for the rest of your inpatient stay. Both the maximum out-of-pocket amount for Part A and Part B medical services and the maximum out-of-pocket amount for inpatient mental health apply to your covered inpatient mental health. This means that once you have paid either $7,550 for Part A and Part B medical services or $1,850 for your inpatient mental health, the plan will cover your inpatient mental health at no cost to you for the rest of your inpatient mental health related stay.

Section 1.6 Our plan does not allow providers to balance bill you

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

Here is how this protection works.

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

- If you believe a provider has balance billed you, call the MVP Medicare Customer Care Center.

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

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

The Medical Benefits Chart on the following pages lists the services MVP Medicare WellSelect with Part D (PPO) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from MVP Medicare WellSelect with Part D (PPO).

  Covered services that need approval in advance to be covered as in-network services are marked by a footnote in the Medical Benefits Chart.

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

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

Other important things to know about our coverage:

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

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

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

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Please note: When you receive outpatient services, the cost sharing listed below in this Medical Benefits Chart generally applies to each service you receive, including multiple services from the same provider, or multiple claims related to the same service. For example, if you have an office visit and your doctor requests diagnostic lab work and radiology services, cost sharing may apply to each service. If you have outpatient surgery, cost sharing may apply to the facility charge and the physician charge.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy.	**In and Out-of-network:** There is a 50% coinsurance per visit for Medicare-covered acupuncture services

Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain (continued) An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Services that are covered for you	**What you must pay** when you get these services
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. The plan will cover only the cost to the nearest appropriate facility. You are financially responsible for all additional costs if you or your representative request transport by ambulance to any other facility, for any reason. Paramedic Intercept Services (PIS) may also be covered. PIS are Advanced Life Support Services that are separate from ambulance transportation. Per Medicare guidelines, these services are only covered if all three of the following conditions existed at the time of service: (1) furnished in a "rural" area (according to CMS or your state); (2) PIS were provided under contract with a volunteer ambulance	**In and Out-of-network:** $200 copayment for each Medicare-covered ground ambulance service. $500 copayment for each Medicare-covered air ambulance service. $0 copayment for each Medicare-covered Paramedic Intercept Service
Annual Routine Physical Exam We cover one routine physical exam per calendar year. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in the Medical Benefits Chart.	There is no coinsurance, copayment, or deductible for the annual

Services that are covered for you	**What you must pay** when you get these services
	routine physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **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.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: One baseline mammogram between the ages of 35 and 39 One screening mammogram every 12 months for women aged 40 and older Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for	**In-network:** There is no coinsurance,

Services that are covered for you	**What you must pay** when you get these services
members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	copayment, or deductible for covered cardiac rehabilitation services. **Out-of-network:** $60 copayment for each Medicare-covered service
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.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: For all women: Pap tests and pelvic exams are covered once every 24 months If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • Maintenance chiropractic therapy that does not meet Medicare criteria is not covered	**In-network:** $15 copayment for each Medicare-covered visit. **Out-of-network:** $20 copayment for each Medicare covered visit
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance

Services that are covered for you	**What you must pay** when you get these services
48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. As of January 1, 2023, 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.	applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay 15% of the Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a 15% coinsurance. The Part B deductible doesn't apply.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Preventive and Comprehensive Dental services.	**In-network:** $45 copayment for all Medicare-covered dental services. **Out-of-network:** $60 copayment for all Medicare-

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

Dental services (continued)
 	
Supplemental Dental Services:
 	
• Preventive services
  ○ Oral exam
  ○ Cleaning
  ○ Dental x-rays
  ○ Fluoride treatment
• Comprehensive Services
  ○ Diagnostic services
  ○ Restorative services
  ○ Endodontics
  ○ Periodontics
  ○ Extractions
  ○ Prosthodontics
  ○ Implants
  ○ Other oral maxillofacial surgery
  ○ Other services
 	
Annual maximum benefit amount applies to supplemental preventive and comprehensive dental services. Once this amount is reached, you are responsible for 100% of the cost of in & out-of-network dental services.
 	
The supplemental preventive and comprehensive dental services are administered by LIBERTY Dental. A maximum allowable benefit amount applies to each service. LIBERTY dentists accept this amount as payment in full for covered services. If you see a dentist that does not participate with LIBERTY Dental, you may be billed for additional costs.
	covered dental services.
	
	Supplemental Dental Services:
	
	$1,500 annual maximum benefit
	
	In-network:
	
	0% coinsurance for all covered supplemental preventive and comprehensive dental services at LIBERTY Dental Plan providers.
	
	Out-of-network:
	
	20%-50% coinsurance for covered supplemental preventive and comprehensive dental services. Coinsurance amount based on service, see the chart at the end of this chapter.
	
	You pay 100% of all other services.

Services that are covered for you	**What you must pay** when you get these services
Dental services (continued) For a complete list of dental codes, services covered and benefit limitations, please see the chart at the end of this chapter.	Any amount you pay for supplemental dental services does not count toward your maximum out-of-pocket amount.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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	**In-network:** $0 copayment per item for each 30-day supply of FreeStyle,

Services that are covered for you	**What you must pay** when you get these services
accuracy of test strips and monitors. Diabetic test strips and blood glucose monitors must be purchased from a preferred manufacturer (FreeStyle, OneTouch, Precision, and Prodigy). Test strips monitors from non-preferred manufacturers are not covered unless there is **prior authorization from MVP**. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	**In-network (continued)** OneTouch, Precision, and Prodigy brand blood glucose test strips or non-preferred strips that have prior authorization. $0 copayment for Medicare covered diabetic supplies. $0 copayment for each Medicare-covered Continuous Glucose Monitor. $0 copayment for each Medicare-covered Continuous Glucose Monitor supplies. 5% coinsurance for diabetic related therapeutic shoes. 5% coinsurance for diabetic

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies (continued)	related custom molded shoe inserts (must be used with diabetic shoes). **Out-of-network:** 40% coinsurance of the cost of Diabetic supplies. 40% coinsurance for diabetic related therapeutic shoes. 40% coinsurance for diabetic related custom molded shoe inserts. $0 copayment for Diabetes self-monitoring training. For insulin and related supplies (e.g. syringes, needles), please see Chapter 6 for Part D cost-sharing

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (continued) (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **mvphealthcare.com/members/find-a-doctor.** Generally, MVP Medicare WellSelect with Part D (PPO) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to MVP Medicare WellSelect with Part D (PPO) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) Non-covered items include, but are not limited to: wigs, air cleaners, air conditioners, bath tub seats, dehumidifiers, elevators, elastic surgical stockings, exercise equipment including exercise bikes and treadmills, grab bars, incontinent pads, institutional hospital beds including oscillating, circulating and Stryker frames, over bed tables, raised toilet seats, shower chairs, standing frame	**In-network (continued):** 20% coinsurance for Medicare-covered durable medical equipment. 20% coinsurance for diabetic related durable medical equipment including insulin pumps. 20% coinsurance for related durable medical equipment supplies. **Out-of-network:** 40% coinsurance for Medicare-covered durable medical equipment and related supplies Your cost sharing for Medicare oxygen equipment

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (continued) systems, whirlpool tubs and pumps, cold therapy devices, therapeutic light box, deep vein thrombosis compression pumps, home modifications such as wheelchair ramps, support railings, bath or home bars, and braces made of elastic or other elastic material. To view or download the full list of non-covered items, visit mvphealthcare.com/members/medicare, then click on Forms/Resources and Claims & Reimbursement Forms. In addition, you may contact the MVP Medicare Customer Care Center. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*) **Prior Authorization from MVP may be required.**	coverage is 20%, every month. After 36 months your cost sharing for Medicare oxygen equipment coverage is $0. The original cost sharing will resume after 5 years. If prior to enrolling in MVP Medicare WellSelect with Part D (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MVP Medicare WellSelect with Part D (PPO) is $0.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: Furnished by a provider qualified to furnish emergency services, and Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. You are covered worldwide for emergency/urgent care. Contact your PCP to help coordinate follow-up care.	**In and Out-of-network:** $95 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital as an Inpatient within 24 hours for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be

Services that are covered for you	**What you must pay** when you get these services
	covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
Emergency Transportation – Worldwide coverage Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered.	**In and Out-of-network:** $200 copayment for Emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered.
Health and wellness education programs **Living Well Programs** - You pay $0 for education classes and support services, such as: physical activity classes, weight management programs, eating healthier, living with arthritis, fall	There is no coinsurance, copayment, or deductible for the Living Well

Services that are covered for you	**What you must pay** when you get these services
prevention workshops, managing congestive heart failure, and Medication Review Program.	Programs.
SilverSneakers® Membership - SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1] . You have access to instructors who lead specially designed group exercise classes[2] . At participating locations nationwide[1] , you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE™ classes, SilverSneakers On-Demand™ videos and our mobile app, SilverSneakers GO™. Plus, you get access to GetSetUp[3] , with thousands of live online classes to ignite your interests in topics like cooking, technology and art. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.**	There is no coinsurance, opayment, or deductible for the SilverSneakers® Fitness program and classes.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs (Continued) **SilverSneakers® Membership (continued)** 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. 3. GetSetUp is a third-party service provider and is not owned or operated by Tivity Health, Inc. ("Tivity") or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality. SilverSneakers and SilverSneakers FLEX are registered trademarks of Tivity Health, Inc. SilverSneakers LIVE, SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved. **Care Management** - Our Care Management programs can help maintain your health with chronic conditions such as congestive heart failure, kidney disease and cancer. **24/7 Nurse Advice Line** - Available 7 days a week to answer your medical questions. Contact the MVP Medicare Customer Care Center for details.	There is no coinsurance, copayment, or deductible for the Care Management programs, or the 24/7 Nurse Advice Line

Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. **Hearing Exam:** 1 routine hearing exam per year. **Hearing Aids:** Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors and are available in rechargeable style options. -OR- Up to $600 per ear toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog every year (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs.* You must see a TruHearing provider to use this benefit. Call **1-855-544-7163** to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 3 year supply of batteries per aid for non-rechargeable models	**Hearing Exam:** $0 copayment for each hearing exam/test. $0 copayment for one routine hearing exam per year. **Hearing Aids:** You pay only $699 for TruHearing Advanced. You pay only $999 for TruHearing Premium. -OR- Up to $600 per ear toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog There is no coinsurance or

Services that are covered for you	**What you must pay** when you get these services
Benefit does not include or cover any of the following: • Over the Counter (OTC) hearing aids • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not in the applicable TruHearing product formulary • Costs associated with loss & damage warranty claims *Costs associated with excluded items are the responsibility of the member and not covered by the plan	copayment for hearing aid fitting/evaluations from TruHearing. Hearing aid costs are not applied to your maximum out-of-pocket amount.
Help with Certain Chronic Conditions If you are diagnosed by a plan provider with the following chronic condition(s), you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing: • Diabetes o Diabetes patients will have reduced cost-sharing for all routine podiatry visits as needed. o The following services are considered to be components of routine foot care, regardless of the provider rendering the service: ▪ The cutting or removal of corns and calluses ▪ Clipping, trimming, or debridement of nails, including debridement of ▪ mycotic nails	You pay $0 copayment for routine podiatry visits if you have a confirmed diabetes diagnosis. If additional services are performed during a routine podiatry visit you may be responsible for the podiatry services cost-share

Services that are covered for you	**What you must pay** when you get these services
▪ Shaving, paring, cutting or removal of keratoma, tyloma, and heloma ▪ Non-definitive simple, palliative treatments like shaving or paring of plantar warts which do not require thermal or chemical cautery and curettage ▪ Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the ▪ absence of localized illness, injury, or symptoms involving the foot o You may be responsible for the podiatry services cost share if additional services are performed during a routine podiatry visit	
• Stroke o Stroke patients may obtain approved bathroom safety and assistance devices. All items must be purchased from DME Supply USA and must be on our approved list.	You are allowed up to $250 per year for bathroom safety and assistance devices if you have a confirmed stroke diagnosis.

Services that are covered for you	**What you must pay** when you get these services
Help with Certain Chronic Conditions (continued)	
• Hypertension o Hypertension patients may receive 1 blood pressure monitoring device per year. The device must be purchased from DME Supply USA and must be on our approved list.	You pay $0 copayment for 1 blood pressure cuff per year if you have a confirmed hypertension diagnosis.
• Rheumatoid Arthritis or Osteoarthritis o Customers who have a prior authorization or have undergone a joint replacement within the plan year with a diagnosis of Rheumatoid Arthritis or Osteoarthritis, can receive a customizable care kit with items such as, but not limited to, a reacher, shoehorn, non-slip bathmat, tieless shoelaces, and long handled shower sponge through our approved contracted vendor.	You pay $0 copayment for a customizable care kit with a confirmed rheumatoid arthritis or osteoarthritis diagnosis following a joint replacement surgery or with a prior authorization for a joint replacement surgery within the plan year.

Services that are covered for you	**What you must pay** when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Prior Authorization may be required by MVP**	**In-network:** $0 copayment for Medicare-covered home health care visits **Out-of-network:** 40% coinsurance per date of service
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).	**In-network:** 20% coinsurance for each Medicare-covered Part B drug.

Services that are covered for you	**What you must pay** when you get these services
Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier **Prior Authorization may be required by MVP**	$0 copayment per Medicare-covered home health visit. 20% coinsurance for each Medicare-covered Durable Medical equipment item. **Out-of-network:** 40% coinsurance for each Medicare-covered Part B drug. 40% copayment per Medicare-covered home health visit. 40% coinsurance for each Medicare-covered Durable Medical equipment item. For Medicare Part D prescriptions, see Chapter 6, Section 5.2 for

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy (continued)	applicable cost share amounts. Supplies are covered in full when medically necessary and provided by a home health care agency
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original	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 MVP Medicare WellSelect with Part D (PPO). **In and Out-of-network:** $0 copayment for hospice

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by MVP Medicare WellSelect with Part D (PPO) but are not covered by Medicare Part A or B: MVP Medicare WellSelect with Part D (PPO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	consultation services

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. Immunizations required for insurance, licensing, employment, marriage, or schools are not covered.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. **In-network:** $0 PCP or $45 Specialist copayment may apply for other immunizations. **Out-of-network:** $5 PCP or $50 Specialist copayment may apply for other immunizations
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-network:** $385 copayment each day, day(s) 1-5; $0 copayment, days 6+

Services that are covered for you	**What you must pay** when you get these services
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MVP Medicare WellSelect with Part D (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.	The above cost-sharing is charged for each inpatient hospital stay. Medicare benefit periods do not apply. (See definition of benefit periods in Chapter 12.) Cost-sharing begins on the first day of admission to the hospital. Cost-sharing does not apply to the date of discharge. If you are transferred from one hospital to another, a new inpatient hospital cost-sharing will be applied.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. • You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**Out-of-network:** 40% coinsurance per admission If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the same cost-sharing you would pay at a network hospital
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**In-network:** $370 copayment each day, day(s) 1-5; $0 copayment, days 6+ The above cost-sharing is charged for each inpatient hospital

Services that are covered for you	**What you must pay** when you get these services
	stay. Medicare benefit periods do not apply. (See definition of benefit periods in Chapter 12.) Cost-sharing begins on the first day of admission to the hospital. Cost-sharing does not apply to the date of discharge. If you are transferred from one hospital to another, a new inpatient hospital cost sharing will be applied. **Out-of-network:** 40% coinsurance per admission

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • 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 from MVP may be required**	**In-network:** $0 copayment for each primary care doctor visit for Medicare-covered services. $45 copayment for each specialist doctor visit for Medicare-covered services. $60 copayment for Medicare-covered x-ray and ultrasounds. $0 copayment for Medicare-covered lab services. 20% coinsurance for Radiation therapy. 20% coinsurance for DME, Orthotics, Prosthetics, and related supplies. $30 copayment for physical, speech, or

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	occupational therapy services. (therapy caps apply) **Out-of-network:** $5 copayment for each primary care doctor visit for Medicare-covered services. $50 copayment for each specialist doctor visit for Medicare-covered services. $60 copayment for Medicare-covered x-ray. 40% coinsurance for Medicare-covered ultrasounds. 40% coinsurance for Medicare-covered lab services.

Services that are covered for you	**What you must pay** when you get these services
	40% coinsurance for Radiation therapy. 40% coinsurance for DME, Orthotics, Prosthetics and related supplies. $60 copayment for physical, speech, or occupational therapy services. (therapy caps apply)
Meals Following an inpatient hospital discharge, we cover up to 14 nutritious meals during a 7-day period to help you meet your nutritional needs and recover. Meals will be delivered to your home and must be from the plan approved provider. **Prior Authorization from MVP is required.**	$0 copayment for home delivered meals following inpatient hospital discharge
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year	There is no coinsurance, copayment, or deductible for members eligible for Medicare-

Services that are covered for you	**What you must pay** when you get these services
after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:	**In-network:** 20% coinsurance for Medicare covered Part B drugs and other Medicare covered items. 20% coinsurance for the total cost of Part B drugs purchased at a pharmacy, administered by a pharmacist, or administered by a health

Services that are covered for you	**What you must pay** when you get these services
	care professional. Office visit copayment may apply. **Out-of-network:** 40% coinsurance for Medicare covered Part B drugs and other Medicare covered items. 40% coinsurance for the total cost of Part B drugs purchased at a pharmacy, administered by a pharmacist, or administered by a health care professional. Office visit copayment may apply.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs (continued) • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Step Therapy may apply to Part B prescription drugs. The following link will take you to a list of Part B drugs that may be subject to Step Therapy https://www.mvphealthcare.com/members/resources/prescription-benefits. We also cover some vaccines under our Part B and Part D prescription drug benefit. **Prior Authorization from MVP may be required** Chapter 5 explains the Part D prescription drug benefit, including rules you	

Services that are covered for you	**What you must pay** when you get these services
must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
🍎 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments **Prior Authorization from MVP may be required**	**In-network:** There is a $10 copayment per Opioid treatment program services **Out-of-network:** There is a $50 copayment per Opioid treatment program services
Outpatient diagnostic tests and therapeutic services and supplies • Covered services include, but are not limited to: • X-rays	**In-network:** $60 copayment for Medicare-covered x-ray and ultrasounds.

Services that are covered for you	**What you must pay** when you get these services
• Radiation (radium and isotope) therapy including technician materials and supplies (office visit co-pay • may apply) • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests **Prior Authorization from MVP may be required**	$150 copayment for each Medicare-covered MRI, CT or PET scan. 20% coinsurance for Radiation therapy (office visit copayment may apply). $0 copayment for Medicare-covered lab services. $20 copayment for Medicare-covered outpatient diagnostic procedures or tests. $0 copayment for blood services

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	**Out-of-network:** $60 copayment for Medicare-covered x-ray. 40% coinsurance for Medicare-covered ultrasounds. 40% coinsurance for each Medicare-covered MRI, CT or PET scan. 40% coinsurance for Radiation therapy (office visit copayment may apply). 40% coinsurance for Medicare-covered lab services. 40% coinsurance for Medicare-covered outpatient diagnostic procedures or tests.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued)	**Out-of-network (continued):** $0 copayment for blood services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network:** $350 copayment for each outpatient hospital observation stay. **Out-of-network:** 40% coinsurance for each outpatient hospital observation stay
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.	**In and Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Prior Authorization from MVP may be required** **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$95 copayment for each emergency room visit. $0 copayment for Medicare-covered screenings and preventive services. **In-network:** $350 copayment for observation services. $350 copayment for Outpatient hospital surgery. $225 copayment for care in a certified ambulatory surgical center. $45 copayment each specialist visit for Medicare-covered services. $0 copayment for Medicare-

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued)	covered lab services. $55 copayment for each Medicare-covered Partial hospitalization service. $60 copayment for Medicare-covered x-ray. **In-network (continued):** $60 copayment for Medicare-covered ultrasounds. $150 copayment for each Medicare-covered MRI, CT or PET scan. $0 copayment for medical supplies $0 copayment for

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued)	Medicare-covered screenings and preventive services. **Out-of-network:** 40% coinsurance for observation services. 40% coinsurance for outpatient hospital surgery. 40% coinsurance for care in a certified ambulatory surgical center. $50 copayment each specialist visit for Medicare-covered services. 40% coinsurance for Medicare-covered lab services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued)	**Out-of-network (continued):** 40% coinsurance for each Medicare-covered Partial hospitalization service. $60 copayment for Medicare-covered x-ray. 40% coinsurance for Medicare-covered ultrasounds. 40% coinsurance for each Medicare-covered MRI, CT or PET scan. 40% coinsurance for medical supplies.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical	**In-network:** $10 copayment for each individual/group

Services that are covered for you	**What you must pay** when you get these services
nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. **Prior Authorization from MVP is required**	Medicare-covered therapy visit. **Out-of-network:** $50 copayment for each individual/group Medicare-covered therapy visit
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-network:** $30 copayment per day for therapy visits. **Out-of-network:** $60 copayment per day for therapy visits. Dollar limits apply to all outpatient therapy services. Dollar limit also applies to therapy services in Skilled Nursing Facilities (SNFs) & hospital

Services that are covered for you	**What you must pay** when you get these services
	outpatient departments.
Outpatient substance abuse services Diagnosis, detoxification (removal of toxic substance), and outpatient rehabilitation services will be provided in cases of substance abuse or addiction. **Prior Authorization from MVP is required**	**In-network:** $10 copayment for each Medicare-covered service **Out-of-network:** $50 copayment for each Medicare-covered service
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. **Prior Authorization from MVP is required**	**In-network:** $350 copayment for each Medicare-covered visit to an outpatient hospital facility. $225 copayment for each Medicare-covered visit to an ambulatory surgical center. **Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
	40% coinsurance for each Medicare-covered visit to an outpatient hospital facility. 40% coinsurance for each Medicare-covered visit to an ambulatory surgical center
Over the Counter (OTC) supplemental coverage Over the Counter (OTC) items are drugs and health related products that do not need a prescription. More than 1,000 OTC items are covered by this plan, as allowed by Medicare. Example of covered items include: • Toothpaste • Eye drops • Nasal spray • Vitamins • Cough drops • Pain relievers • Antacids • First aid items • And more... Here are the ways to access your benefit: • Place orders online at MVP.NationsBenefits.com through the web for home delivery.	This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to $75 every quarter Unused funds do not rollover to the following quarter Unused funds do not rollover to the following calendar year

Services that are covered for you	**What you must pay** when you get these services
• Shop in stores using your OTC benefit card at participating retailers • Call 1-833-SHOP-OTC (1-833-746-7682) TTY:711 Monday thru Friday 8am – 8pm Eastern Standard time to place an order. Pick items from the OTC catalog. Have your product names, OTC benefit card number and delivery information ready. Purchases are limited to the available benefit dollars. Unused amounts will not roll over to the next quarter or the following calendar year. All orders must be place through the plans approved vendor or purchased at a participating retail store. Specific name brands may not be available, and quantities may be limited or restricted. After Plan paid OTC benefits, you are responsible for the remaining cost. **Please contact 1-833 SHOP-OTC (1-833-746-7682) TTY:711 or the MVP Medicare Customer Care Center if you have questions about this benefit.**	
Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than	**In-network:** $55 copayment for each Medicare-covered partial

Services that are covered for you	**What you must pay** when you get these services
the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Prior Authorization from MVP is required**	hospitalization service **Out-of-network:** 40% copayment for each Medicare-covered partial hospitalization service
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment Certain telehealth services, including: Emergency/Post stabilization services, urgently needed services, individual sessions for mental health and psychiatry specialty services, and nutritional consultation. ○ 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 or the plan approved virtual care services provider. ▪ MVP virtual care services through Gia are available at no cost-share for most members. In-person visits and referrals are subject to	**In-network:** $0 copayment for each primary care doctor office visit for Medicare-covered services. $45 copayment for each specialist visit for Medicare-covered services You pay no copayment or coinsurance for a telehealth (virtual care) visit for services through the plan approved virtual care provider. You will pay the

Services that are covered for you	**What you must pay** when you get these services
cost-share per plan. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	applicable cost share for a service for a telehealth visit through providers other than the plan approved virtual care provider. **Out-of-network:** $5 copayment for each primary care doctor office visit for Medicare-covered services. $50 copayment for each specialist visit for Medicare-covered services See "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" earlier in this chart for any applicable copayments or coinsurance

Services that are covered for you	**What you must pay** when you get these services
• Consultation your doctor has with other doctors by phone, internet, or electronic health record • 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 from MVP may be required**	amounts for ambulatory surgical center visits or in a hospital outpatient setting.
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 **Prior Authorization from MVP may be required**	**In-network:** $45 copayment for each Medicare-covered visit (medically necessary foot care). **Out-of-network:** $50 copayment for each Medicare-covered visit (medically necessary foot care).

Services that are covered for you	**What you must pay** when you get these services
Prostate cancer screening exams For men, age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail. **Prior Authorization from MVP may be required**	**In-network:** 20% coinsurance for Medicare covered Prosthetic devices. 20% coinsurance for related supplies. **Out-of-network:** 40% coinsurance for Medicare covered Prosthetic devices. 40% coinsurance for related supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic	**In-network:** There is no co-pay or co-

Services that are covered for you	**What you must pay** when you get these services
obstructive pulmonary disease (COPD) and order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	insurance for Medicare-covered pulmonary rehabilitation services **Out-of-network:** $60 copayment for Medicare-covered pulmonary rehabilitation services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of	There is no coinsurance, copayment, or

Services that are covered for you	**What you must pay** when you get these services
tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include:	**In and Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section*, Medicare Part B prescription drugs*. **Prior Authorization from MVP may be required**	$0 copayment for Medicare-covered Kidney Disease Education services. 20% coinsurance for outpatient dialysis treatments. Office visit copayment may apply
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) A 3-day hospital admission is not required prior to coverage. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	**In-network:** $0 copayment each day for day(s) 1-20 in a network skilled nursing facility. $203 copayment each day for day(s) 21-100 in a

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (continued) • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital **Prior Authorization from MVP is required**	network skilled nursing facility. You are covered for up to 100 days each benefit period. You pay 100% of the cost over 100 days in a benefit period. A benefit period begins on the day of admission to a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. **Out-of-network:** 40% coinsurance for days 1-100 in a skilled nursing facility.

Services that are covered for you	**What you must pay** when you get these services
	You are covered for up to 100 days each benefit period. You pay 100% of the cost over 100 days in a benefit period. A benefit period begins on the day of admission to a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use

Services that are covered for you	**What you must pay** when you get these services
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication Be conducted in a hospital outpatient setting or a physician's office Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In-network:** $25 copayment for each Medicare-covered exercise therapy session **Out-of-network:** $60 copayment for each Medicare-covered exercise therapy session

Services that are covered for you	**What you must pay** when you get these services
Transportation (Non-Emergency) Non-emergency transportation to plan-approved locations such as to a doctor's office visit, pharmacies and dialysis centers. MVP helps to coordinate rides that are appropriate for your health needs. This can be in the form of a ride-share, medical sedan, wheelchair accessible van, bariatric wheelchair accessible van and gurney transport **Rides must be scheduled through the plan approved vendor.** 26 one-way trips maximum per calendar year 30-mile limit per trip **This benefit is not to be used for emergency situations. For Emergency transportation: See Ambulance.** Contact the MVP Medicare Customer Care Center for additional details on how to access this benefit.	You pay $0 per one-way ride to an MVP approved location 26 one-way trips maximum per calendar year 30-mile limit applies per trip Rides must be coordinated through MVP's transportation coordinator. Call American Logistics at 1-855-923-4125 Monday – Friday 8 a.m. – 5 p.m. or contact the MVP Medicare Customer Care Center (numbers and hours on the back of this book)
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to	**In and Out-of-network:** $30 copayment for each urgently needed care visit,

Services that are covered for you	**What you must pay** when you get these services
immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan. and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. You are covered for urgently needed care worldwide. Contact your PCP to help coordinate follow-up care.	In or Out-of-network. $95 copayment for each worldwide emergency or worldwide urgent care visit
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year	**In-network:** $20 copayment for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. $0 copayment for Medicare-covered

Services that are covered for you	**What you must pay** when you get these services
Vision care (continued) • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Eyewear coverage following cataract surgery is based on Medicare allowed payment rates. MVP does not cover eyewear upgrades or enhancements that are not medically necessary or covered by Medicare. Only routine intraocular lenses (IOL's) to replace a damaged lens are covered. Intraocular lenses implanted during cataract surgery to correct presbyopia or astigmatism are not covered. • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • One routine eye exam per year. • Eyewear benefit allowance every calendar year toward the purchase of supplemental eyeglasses or contact lenses. Nonprescription eyewear and safety glasses required for employment are not covered. • Supplemental eyewear allowance applied to the retail value only. Store discounts and promotional offers cannot be combined with the eyewear allowance.	glaucoma screenings 20% coinsurance of the Medicare allowed amount for eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). **Out-of-network:** $60 copayment for an eye exam to diagnose and treat diseases and conditions of the eye. 40% coinsurance of the Medicare allowed amount for eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). **Out-of-network (continued):** $0 copayment for glaucoma screenings

Services that are covered for you	**What you must pay** when you get these services
Vision care (continued)	**In and out-of-network:** $150 benefit allowance every calendar year for supplemental eyewear. $0 copayment for a routine eye exam through a plan or non-plan provider with plan benefit payable up to a $300 maximum. Limited to one routine eye exam per calendar year. If diagnostic eye exam services are performed during a routine eye exam you will be responsible for the diagnostic eye exam cost-share.
Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need	There is no coinsurance, copayment, or deductible for

Services that are covered for you	**What you must pay** when you get these services
(including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	the Welcome to Medicare preventive visit.

SECTION 3 What services are not covered by the plan?

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances.

Services not covered by Medicare	Not covered under any condition	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 does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home.	✓	
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), Over the Counter (OTC) hearing aids, ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 3 year supply of free batteries per non-rechargeable aid purchased).	✓	
Home-delivered meals		Home-delivered meals covered following inpatient hospitalizations. See the benefits chart in Chapter 4 for benefit details.
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Over-the-counter (OTC) items		See Over-the-Counter (OTC) section in the benefits chart in Chapter 4 for benefit details.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		• Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.		See Dental Services section in the benefits chart in Chapter 4 for benefit details.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		• Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. • Additional vision benefits are included with your plan. See Vision Care section in the benefits chart in Chapter 4 for benefit details.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care		• Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards	✓	

Dental Coverage

The chart below contains the complete list of dental codes and procedures covered by the plan. We will only cover the codes that are listed in the chart below.

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D0120	Periodic oral evaluation	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0140	Limited oral evaluation	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0150	Comprehensive oral evaluation	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0160	Oral evaluation, problem focused	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0170	Re-evaluation, limited, problem focused	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D0171	Re-evaluation, post operative office visit	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0180	Comprehensive periodontal evaluation	Oral Exams	0%	20%	2 of (D0120-D0180) every calendar year
D0190	Screening of a patient	Oral Exams	0%	20%	
D0210	Intraoral, comprehensive series of radiographic images	Dental X-Rays	0%	20%	1 of (D0210, D0330, D0709) every 3 calendar years
D0220	Intraoral, periapical, first radiographic image	Dental X-Rays	0%	20%	N/A
D0230	Intraoral, periapical, each add 'l radiographic image	Dental X-Rays	0%	20%	N/A
D0270	Bitewing, single radiographic image	Dental X-Rays	0%	20%	2 of (D0270-D0274, D0708) every calendar year
D0272	Bitewings, two radiographic images	Dental X-Rays	0%	20%	2 of (D0270-D0274, D0708) every calendar year
D0273	Bitewings, three radiographic images	Dental X-Rays	0%	20%	2 of (D0270-D0274, D0708) every calendar year
D0274	Bitewings, four radiographic images	Dental X-Rays	0%	20%	2 of (D0270-D0274, D0708)

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					every calendar year
D0277	Vertical bitewings, 7 to 8 radiographic images	Dental X-Rays	0%	20%	1 (D0277) every 3 calendar years
D0330	Panoramic radiographic image	Dental X-Rays	0%	20%	1 of (D0210, D0330, D0709) every 3 calendar years
D0364	Cone beam CT capture & interpretation, limited view, less than one whole jaw	Dental X-Rays	0%	20%	N/A
D0365	Cone beam CT capture & interpretation, view of one full arch, mandible	Dental X-Rays	0%	20%	N/A
D0366	Cone beam CT capture & interpretation, view of one full arch, maxilla, cranium	Dental X-Rays	0%	20%	N/A
D0367	Cone beam CT capture & interpretation, view of both jaws; cranium	Dental X-Rays	0%	20%	N/A
D0368	Cone beam CT capture and interpretation for TMJ series including two	Dental X-Rays	0%	20%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	or more exposures				
D0380	Cone beam CT image capture with limited field of view, less than one whole jaw	Dental X-Rays	0%	20%	N/A
D0381	Cone beam CT image capture with field of view of one full dental arch, mandible	Dental X-Rays	0%	20%	N/A
D0382	Cone beam CT image capture with field of view of one full dental arch, maxilla	Dental X-Rays	0%	20%	N/A
D0383	Cone beam CT image capture with field of view of both jaws	Dental X-Rays	0%	20%	N/A
D0384	Cone beam CT image capture for TMJ series including two or more exposures	Dental X-Rays	0%	20%	N/A
D0431	Adjunctive pre-diagnostic test	Diagnostic Services	0%	20%	N/A
D0460	Pulp vitality tests	Diagnostic Services	0%	20%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D0470	Diagnostic casts	Diagnostic Services	0%	20%	N/A
D0601	Caries risk assessment and documentation, low risk	Diagnostic Services	0%	20%	N/A
D0602	Caries risk assessment and documentation, moderate risk	Diagnostic Services	0%	20%	N/A
D0603	Caries risk assessment and documentation, high risk	Diagnostic Services	0%	20%	N/A
D0707	Intraoral, periapical radiographic image, image capture only	Dental X-Rays	0%	20%	N/A
D0708	Intraoral, bitewing radiographic image, image capture only	Dental X-Rays	0%	20%	2 of (D0270-D0274, D0708) every calendar year
D0709	Intraoral, comprehensive series of radiographic images, image capture only	Dental X-Rays	0%	20%	1 of (D0210, D0330, D0709) every 3 calendar years
D1110	Prophylaxis, adult	Prophylaxis (Cleaning)	0%	20%	2 of (D1110, D4346, D4910) every calendar year
D1206	Topical application of fluoride varnish	Fluoride Treatment	0%	20%	1 every 12 months per procedure

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D1208	Topical application of fluoride, excluding varnish	Fluoride Treatment	0%	20%	1 every 12 months per procedure
D2140	Amalgam, one surface, primary or permanent	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2150	Amalgam, two surfaces, primary or permanent	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2160	Amalgam, three surfaces, primary or permanent	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2161	Amalgam, four or more surfaces, primary or permanent	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2330	Resin-based composite, one surface, anterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2331	Resin-based composite, two surfaces, anterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D2332	Resin-based composite, three surfaces, anterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2335	Resin-based composite, four or more surfaces, involving incisal angle	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2390	Resin-based composite crown, anterior	Restorative Services	0%	20%	1 (D2390) per tooth every 2 calendar years
D2391	Resin-based composite, one surface, posterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2392	Resin-based composite, two surfaces, posterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2393	Resin-based composite, three surfaces, posterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D2394	Resin-based composite, four or more surfaces, posterior	Restorative Services	0%	20%	1 of (D2140-D2394) per surface, per tooth every 2 calendar years
D7140	Extraction, erupted tooth	Extractions	0%	20%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	or exposed root				
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	Extractions	0%	20%	N/A
D2542	Onlay, metallic, two surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2543	Onlay, metallic, three surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2544	Onlay, metallic, four or more surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2620	Inlay, porcelain/ceramic, two surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2630	Inlay, porcelain/ceramic, three or more surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2642	Onlay, porcelain/cera	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	mic, two surfaces				tooth every 5 calendar years
D2643	Onlay, porcelain/ceramic, three surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2644	Onlay, porcelain/ceramic, four or more surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2651	Inlay, resin-based composite, two surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2652	Inlay, resin-based composite, three or more surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2662	Onlay, resin-based composite, two surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2663	Onlay, resin-based composite, three surfaces	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2664	Onlay, resin-based composite, four	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	or more surfaces				tooth every 5 calendar years
D2710	Crown, resin-based composite (indirect)	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2712	Crown, ¾ resin-based composite (indirect)	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2720	Crown, resin with high noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2721	Crown, resin with predominantly base metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2722	Crown, resin with noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2740	Crown, porcelain/ceramic	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2750	Crown, porcelain fused to high noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D2751	Crown, porcelain fused to predominantly base metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2752	Crown, porcelain fused to noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2780	Crown, ¾ cast high noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2781	Crown, ¾ cast predominantly base metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2782	Crown, ¾ cast noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2783	Crown, ¾ porcelain/ceramic	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2790	Crown, full cast high noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D2791	Crown, full cast predominantly base metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2792	Crown, full cast noble metal	Restorative Services	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	Restorative Services	0%	50%	N/A
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	Restorative Services	0%	50%	N/A
D2920	Re-cement or re-bond crown	Restorative Services	0%	50%	N/A
D2921	Reattachment of tooth fragment, incisal edge or cusp	Restorative Services	0%	50%	N/A
D2950	Core buildup, including any pins when required	Restorative Services	0%	50%	1 (D2950) per tooth every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D2951	Pin retention, per tooth, in addition to restoration	Restorative Services	0%	50%	1 (D2951) per tooth every 5 calendar years
D2952	Post and core in addition to crown, indirectly fabricated	Restorative Services	0%	50%	1 of (D2952, D2954) per tooth every 5 calendar years
D2953	Each additional indirectly fabricated post, same tooth	Restorative Services	0%	50%	1 of (D2953, D2957) per tooth every 5 calendar years
D2954	Prefabricated post and core in addition to crown	Restorative Services	0%	50%	1 of (D2952, D2954) per tooth every 5 calendar years
D2955	Post removal	Restorative Services	0%	50%	1 (D2955) per tooth every 5 calendar years
D2957	Each additional prefabricated post, same tooth	Restorative Services	0%	50%	1 of (D2953, D2957) per tooth every 5 calendar years
D3110	Pulp cap, direct (excluding final restoration)	Endodontics	0%	50%	1 of (D3110, D3120) per tooth in a lifetime
D3120	Pulp cap, indirect (excluding final restoration)	Endodontics	0%	50%	1 of (D3110, D3120) per tooth in a lifetime
D3220	Therapeutic pulpotomy (excluding final restoration)	Endodontics	0%	50%	1 (D3220) per tooth in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D3221	Pulpal debridement, primary and permanent teeth	Endodontics	0%	50%	1 (D3221) per tooth in a lifetime
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	Endodontics	0%	50%	1 (D3222) per tooth in a lifetime
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	Endodontics	0%	50%	1 of (D3230, D3240) per tooth in a lifetime
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	Endodontics	0%	50%	1 of (D3230, D3240) per tooth in a lifetime
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Endodontics	0%	50%	1 of (D3310-D3330) per tooth in a lifetime
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Endodontics	0%	50%	1 of (D3310-D3330) per tooth in a lifetime
D3330	Endodontic therapy, molar tooth	Endodontics	0%	50%	1 of (D3310-D3330) per tooth in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	(excluding final restoration)				
D3331	Treatment of root canal obstruction; non-surgical access	Endodontics	0%	50%	1 (D3331) per tooth in a lifetime
D3332	Incomplete endodontic therapy; inoperable, unrestorable, fractured tooth	Endodontics	0%	50%	1 (D3332) per tooth in a lifetime
D3333	Internal root repair of perforation defects	Endodontics	0%	50%	1 (D3333) per tooth in a lifetime
D3346	Retreatment of previous root canal therapy, anterior	Endodontics	0%	50%	1 of (D3346-D3348) per tooth in a lifetime; not payable within 12 months if performed by same provider
D3347	Retreatment of previous root canal therapy, premolar	Endodontics	0%	50%	1 of (D3346-D3348) per tooth in a lifetime; not payable within 12 months if performed by same provider

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D3348	Retreatment of previous root canal therapy, molar	Endodontics	0%	50%	1 of (D3346-D3348) per tooth in a lifetime; not payable within 12 months if performed by same provider
D3351	Apexification/recalcification, initial visit	Endodontics	0%	50%	1 of (D3351) per tooth in a lifetime
D3352	Apexification/recalcification, interim medication replacement	Endodontics	0%	50%	1 of (D3352) per tooth in a lifetime
D3353	Apexification/recalcification, final visit	Endodontics	0%	50%	1 of (D3353) per tooth in a lifetime
D3410	Apicoectomy, anterior	Endodontics	0%	50%	1 of (D3410-D3425) per tooth in a lifetime
D3421	Apicoectomy, premolar (first root)	Endodontics	0%	50%	1 of (D3410-D3425) per tooth in a lifetime
D3425	Apicoectomy, molar (first root)	Endodontics	0%	50%	1 of (D3410-D3425) per tooth in a lifetime
D3426	Apicoectomy, (each additional root)	Endodontics	0%	50%	1 (D3426) per tooth in a lifetime
D3428	Bone graft in conjunction with	Endodontics	0%	50%	1 of (D3428, D3429) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	periradicular surgery, per tooth, single site				tooth in a lifetime
D3429	Bone graft in conjunction with periradicular surgery, each add'l tooth, same site	Endodontics	0%	50%	1 of (D3428, D3429) per tooth in a lifetime
D3430	Retrograde filling, per root	Endodontics	0%	50%	1 (D3430) per tooth in a lifetime
D3431	Biologic materials, soft osseous tissue regeneration with periradicular surgery	Endodontics	0%	50%	1 of (D3431, D3432) per site in a lifetime
D3432	Guided tissue regeneration, per site, with periradicular surgery	Endodontics	0%	50%	1 of (D3431, D3432) per site in a lifetime
D3450	Root amputation, per root	Endodontics	0%	50%	1 (D3450) per tooth in a lifetime
D3920	Hemisection, not including root canal therapy	Endodontics	0%	50%	1 (D3920) per tooth in a lifetime
D4210	Gingivectomy or gingivoplasty, four or more	Periodontics	0%	50%	1 of (D4210-D4212) per site/quad every

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	teeth per quadrant				3 calendar years
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	Periodontics	0%	50%	1 of (D4210-D4212) per site/quad every 3 calendar years
D4212	Gingivectomy or gingivoplasty, restorative procedure, per tooth	Periodontics	0%	50%	1 of (D4210-D4212) per site/quad every 3 calendar years
D4230	Anatomical crown exposure, four or more contiguous teeth per quadrant	Periodontics	0%	50%	1 of (D4230, D4231) per site/quad every 3 calendar years
D4231	Anatomical crown exposure, one to three teeth per quadrant	Periodontics	0%	50%	1 of (D4230, D4231) per site/quad every 3 calendar years
D4240	Gingival flap procedure, four or more teeth per quadrant	Periodontics	0%	50%	1 of (D4240-D4245) per site/quad every 3 calendar years
D4241	Gingival flap procedure, one to three teeth per quadrant	Periodontics	0%	50%	1 of (D4240-D4245) per site/quad every 3 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D4245	Apically positioned flap	Periodontics	0%	50%	1 of (D4240-D4245) per site/quad every 3 calendar years
D4249	Clinical crown lengthening, hard tissue	Periodontics	0%	50%	1 (D4249) per tooth in a lifetime
D4260	Osseous surgery, four or more teeth per quadrant	Periodontics	0%	50%	1 of (D4260, D4261) per site/quad every 5 calendar years
D4261	Osseous surgery, one to three teeth per quadrant	Periodontics	0%	50%	1 of (D4260, D4261) per site/quad every 5 calendar years
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	Periodontics	0%	50%	1 of (D4263, D4264) per site/quad in a lifetime
D4264	Bone replacement graft, retained natural tooth, each additional site	Periodontics	0%	50%	1 of (D4263, D4264) per site/quad in a lifetime
D4266	Guided tissue regeneration, natural teeth, resorbable barrier, per site	Periodontics	0%	50%	1 of (D4266, D4267) per site/quad every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D4267	Guided tissue regeneration, natural teeth, non-resorbable barrier, per site	Periodontics	0%	50%	1 of (D4266, D4267) per site/quad every 5 calendar years
D4268	Surgical revision procedure, per tooth	Periodontics	0%	50%	1 (D4268) per tooth every 3 calendar years
D4270	Pedicle soft tissue graft procedure	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4273	Autogenous connective tissue graft procedure, first tooth	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4274	Mesial/distal wedge procedure, single tooth	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4275	Non-autogenous connective tissue graft, first tooth	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4276	Combined connective tissue and pedicle graft	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4277	Free soft tissue graft, first tooth	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					3 calendar years
D4278	Free soft tissue graft, each additional tooth	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	Periodontics	0%	50%	1 of (D4270-D4285) per site/quad every 3 calendar years
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	Periodontics	0%	50%	1 of (D4322, D4323) per arch every 3 calendar years
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	Periodontics	0%	50%	1 of (D4322, D4323) per arch every 3 calendar years
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	Periodontics	0%	50%	1 of (D4341, D4342) per site/quad every 2 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D4342	Periodontal scaling and root planing, one to three teeth per quadrant	Periodontics	0%	50%	1 of (D4341, D4342) per site/quad every 2 calendar years
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	Periodontics	0%	50%	2 of (D1110, D4346, D4910) every calendar year
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	Periodontics	0%	50%	1 (D4355) every 2 calendar years
D4910	Periodontal maintenance	Periodontics	0%	50%	2 of (D1110, D4346, D4910) every calendar year
D4921	Gingival irrigation with a medicinal agent, per quadrant	Periodontics	0%	50%	1 (D4921) per quad every 2 calendar years
D5110	Complete denture, maxillary	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D5120	Complete denture, mandibular	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5130	Immediate denture, maxillary	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5140	Immediate denture, mandibular	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5211	Maxillary partial denture, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5212	Mandibular partial denture, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5213	Maxillary partial denture, cast metal, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5214	Mandibular partial denture, cast metal, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D5221	Immediate maxillary partial denture, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5222	Immediate mandibular partial denture, resin base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5225	Maxillary partial denture, flexible base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5226	Mandibular partial denture, flexible base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5227	Immediate maxillary partial	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	denture, flexible base				arch every 5 calendar years
D5228	Immediate mandibular partial denture, flexible base	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5410	Adjust complete denture, maxillary	Removable Prosthodontics	0%	50%	1 of (D5410-D5422) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5411	Adjust complete denture, mandibular	Removable Prosthodontics	0%	50%	1 of (D5410-D5422) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5421	Adjust partial denture, maxillary	Removable Prosthodontics	0%	50%	1 of (D5410-D5422) per arch every calendar year; not payable within 6 months of

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					initial placement by the same provider
D5422	Adjust partial denture, mandibular	Removable Prosthodontics	0%	50%	1 of (D5410-D5422) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5511	Repair broken complete denture base, mandibular	Removable Prosthodontics	0%	50%	1 of (D5511, D5512) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5512	Repair broken complete denture base, maxillary	Removable Prosthodontics	0%	50%	1 of (D5511, D5512) per arch every calendar year; not payable within 6 months of initial placement by

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					the same provider
D5520	Replace missing or broken teeth, complete denture	Removable Prosthodontics	0%	50%	1 (D5520) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5611	Repair resin partial denture base, mandibular	Removable Prosthodontics	0%	50%	1 of (D5611-D5622) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5612	Repair resin partial denture base, maxillary	Removable Prosthodontics	0%	50%	1 of (D5611-D5622) per arch every calendar year; not payable within 6 months of initial placement by the same provider

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D5621	Repair cast partial framework, mandibular	Removable Prosthodontics	0%	50%	1 of (D5611-D5622) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5622	Repair cast partial framework, maxillary	Removable Prosthodontics	0%	50%	1 of (D5611-D5622) per arch every calendar year; not payable within 6 months of initial placement by the same provider
D5630	Repair or replace broken retentive clasping materials, per tooth	Removable Prosthodontics	0%	50%	1 (D5630) per tooth every calendar year; not payable within 6 months of initial placement by the same provider
D5640	Replace broken teeth, per tooth	Removable Prosthodontics	0%	50%	1 (D5640) per tooth every calendar year; not payable within 6

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					months of initial placement by the same provider
D5650	Add tooth to existing partial denture	Removable Prosthodontics	0%	50%	1 (D5650) per tooth every calendar year; not payable within 6 months of initial placement by the same provider
D5660	Add clasp to existing partial denture, per tooth	Removable Prosthodontics	0%	50%	1 (D5660) per tooth every calendar year; not payable within 6 months of initial placement by the same provider
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	Removable Prosthodontics	0%	50%	1 of (D5670, D5671) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	Removable Prosthodontics	0%	50%	1 of (D5670, D5671) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5710	Rebase complete maxillary denture	Removable Prosthodontics	0%	50%	1 of (D5710-D5721 per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5711	Rebase complete mandibular denture	Removable Prosthodontics	0%	50%	1 of (D5710-D5721 per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D5720	Rebase maxillary partial denture	Removable Prosthodontics	0%	50%	1 of (D5710-D5721 per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5721	Rebase mandibular partial denture	Removable Prosthodontics	0%	50%	1 of (D5710-D5721 per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5725	Rebase hybrid prosthesis	Removable Prosthodontics	0%	50%	1 of (D5725) per site every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5730	Reline complete maxillary denture, direct	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					within 6 months of initial placement by the same provider
D5731	Reline complete mandibular denture, direct	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5740	Reline maxillary partial denture, direct	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5741	Reline mandibular partial denture, direct	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					the same provider
D5750	Reline complete maxillary denture, indirect	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5751	Reline complete mandibular denture, indirect	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5760	Reline maxillary partial denture, indirect	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					the same provider
D5761	Reline mandibular partial denture, indirect	Removable Prosthodontics	0%	50%	1 of (D5730-D5761) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5765	Soft liner for complete or partial removable denture, indirect	Removable Prosthodontics	0%	50%	1 (D5765) per arch every 2 calendar years; not payable within 6 months of initial placement by the same provider
D5850	Tissue conditioning, maxillary	Removable Prosthodontics	0%	50%	1 of (D5850, D5851) per arch every calendar year
D5851	Tissue conditioning, mandibular	Removable Prosthodontics	0%	50%	1 of (D5850, D5851) per arch every calendar year
D5863	Overdenture, complete, maxillary	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					arch every 5 calendar years
D5864	Overdenture, partial, maxillary	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5865	Overdenture, complete, mandibular	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5866	Overdenture, partial, mandibular	Removable Prosthodontics	0%	50%	1 of (D5110-D5228, D5863-D5866) per arch every 5 calendar years
D5867	Replacement of part of semi-precision, precision attachment, per attachment	Removable Prosthodontics	0%	50%	1 of (D5867, D5899) per site every 5 calendar years
D5899	Unspecified removable prosthodontic procedure, by report	Removable Prosthodontics	0%	50%	1 of (D5867, D5899) per site every 5 calendar years
D6010	Surgical placement of implant body, endosteal	Implants	0%	50%	1 of (D6010, D6013) per tooth in a lifetime
D6011	Surgical access to an implant body (second	Implants	0%	50%	1 (D6011) per tooth in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	state implant surgery)				
D6013	Surgical placement of mini implant	Implants	0%	50%	1 of (D6010, D6013) per tooth in a lifetime
D6056	Prefabricated abutment, includes modification and placement	Implants	0%	50%	1 of (D6056, D6057) per tooth every 5 calendar years
D6057	Custom fabricated abutment, includes placement	Implants	0%	50%	1 of (D6056, D6057) per tooth every 5 calendar years
D6058	Abutment supported porcelain/ceramic crown	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6059	Abutment supported porcelain fused to high noble crown	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6060	Abutment supported porcelain fused to base metal crown	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6061	Abutment supported porcelain fused to noble metal crown	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6062	Abutment supported cast metal crown, high noble	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6063	Abutment supported cast metal crown, base metal	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6064	Abutment supported cast metal crown, noble metal	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6065	Implant supported porcelain/ceramic crown	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6066	Implant supported crown, porcelain fused to high noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6067	Implant supported crown, high noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6068	Abutment supported retainer, porcelain/ceramic FPD	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6069	Abutment supported retainer, metal FPD, high noble	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6070	Abutment supported retainer, porcelain fused	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	to metal FPD, base metal				tooth every 5 calendar years
D6071	Abutment supported retainer, porcelain fused to metal FPD, noble	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6072	Abutment supported retainer, cast metal FPD, high noble	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6073	Abutment supported retainer, cast metal FPD, base metal	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6074	Abutment supported retainer, cast metal FPD, noble	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6075	Implant supported retainer for ceramic FPD	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6076	Implant supported retainer for FPD, porcelain fused to high noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6080	Implant maintenance procedures, prosthesis removed/reinserted, including cleansing	Implants	0%	50%	N/A
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	Implants	0%	50%	1 (D6081) per tooth every 2 calendar years
D6082	Implant supported crown, porcelain fused to predominantly base alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6083	Implant supported crown, porcelain fused to noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6086	Implant supported crown, predominantly base alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6087	Implant supported crown, noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6090	Repair implant supported prosthesis, by report	Implants	0%	50%	N/A
D6091	Replacement part of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	Implants	0%	50%	N/A
D6092	Re-cement or re-bond implant/abutment supported crown	Implants	0%	50%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D6093	Re-cement or re-bond implant/abutment supported FPD	Implants	0%	50%	N/A
D6095	Repair implant abutment, by report	Implants	0%	50%	N/A
D6096	Remove broken implant retaining screw	Implants	0%	50%	N/A
D6098	Implant supported retainer, porcelain fused to predominantly base alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6099	Implant supported retainer for FPD, porcelain fused to noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6100	Surgical removal of implant body	Implants	0%	50%	N/A
D6104	Bone graft at time of implant placement	Implants	0%	50%	1 (D6104) per site in a lifetime
D6110	Implant/abutment supported removable denture, maxillary	Implants	0%	50%	1 of (D6110-D6113) per arch every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D6111	Implant/abutment supported removable denture, mandibular	Implants	0%	50%	1 of (D6110-D6113) per arch every 5 calendar years
D6112	Implant/abutment supported removable denture, partial, maxillary	Implants	0%	50%	1 of (D6110-D6113) per arch every 5 calendar years
D6113	Implant/abutment supported removable denture, partial, mandibular	Implants	0%	50%	1 of (D6110-D6113) per arch every 5 calendar years
D6114	Implant/abutment supported fixed denture, maxillary	Implants	0%	50%	1 of (D6114-D6117) per arch every 5 calendar years
D6115	Implant/abutment supported fixed denture, mandibular	Implants	0%	50%	1 of (D6114-D6117) per arch every 5 calendar years
D6116	Implant/abutment supported fixed denture for partial, maxillary	Implants	0%	50%	1 of (D6114-D6117) per arch every 5 calendar years
D6117	Implant/abutment supported fixed denture for partial, mandibular	Implants	0%	50%	1 of (D6114-D6117) per arch every 5 calendar years
D6121	Implant supported retainer for metal FPD,	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121,

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	predominantly base alloys				D6122) per tooth every 5 calendar years
D6122	Implant supported retainer for metal FPD, noble alloys	Implants	0%	50%	1 of (D6058-D6076, D6082-D6087, D6098, D6099, D6121, D6122) per tooth every 5 calendar years
D6191	Semi-precision abutment, placement	Implants	0%	50%	1 of (D6191, D6192) per tooth every 5 calendar years
D6192	Semi-precision attachment, placement	Implants	0%	50%	1 of (D6191, D6192) per tooth every 5 calendar years
D6205	Pontic, indirect resin based composite	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6210	Pontic, cast high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6211	Pontic, cast predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6212	Pontic, cast noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6240	Pontic, porcelain fused to high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6241	Pontic, porcelain fused to predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6242	Pontic, porcelain fused to noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6245	Pontic, porcelain/ceramic	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6250	Pontic, resin with high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6251	Pontic, resin with predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6252	Pontic, resin with noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6545	Retainer, cast metal for resin bonded fixed prosthesis	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6548	Retainer, porcelain/ceramic, resin bonded fixed prosthesis	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6549	Resin retainer, for resin bonded fixed prosthesis	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6600	Retainer inlay, porcelain/ceramic, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6601	Retainer inlay, porcelain/ceramic, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6602	Retainer inlay, cast high noble metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6603	Retainer inlay, cast high noble metal, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6604	Retainer inlay, cast base metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6605	Retainer inlay, cast base metal, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6606	Retainer inlay, cast noble metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6607	Retainer inlay, cast noble metal, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6608	Retainer onlay, porcelain/ceramic, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6609	Retainer onlay, porcelain/ceramic, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6610	Retainer onlay, cast high noble metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6611	Retainer onlay, cast high noble metal, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6612	Retainer onlay, cast base metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6613	Retainer onlay, cast base metal, three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6614	Retainer onlay, cast noble metal, two surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6615	Retainer onlay, cast noble metal three or more surfaces	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6710	Retainer crown, indirect resin based composite	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6720	Retainer crown, resin with high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6721	Retainer crown, resin with predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6722	Retainer crown, resin with noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6740	Retainer crown, porcelain/ceramic	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6750	Retainer crown, porcelain fused to high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6751	Retainer crown, porcelain fused to predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6752	Retainer crown, porcelain fused to noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6780	Retainer crown, ¾ cast high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
					tooth every 5 calendar years
D6781	Retainer crown, ¾ cast predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6782	Retainer crown, ¾ cast noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6783	Retainer crown, ¾ porcelain/ceramic	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6790	Retainer crown, full cast high noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6791	Retainer crown, full cast predominantly base metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6792	Retainer crown, full cast noble metal	Fixed Prosthodontics	0%	50%	1 of (D2542-D2792, D6205-D6792) per tooth every 5 calendar years
D6930	Re-cement or re-bond fixed partial denture	Fixed Prosthodontics	0%	50%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D6980	Fixed partial denture repair, restorative material failure	Fixed Prosthodontics	0%	50%	N/A
D7220	Removal of impacted tooth, soft tissue	Extractions	0%	50%	N/A
D7230	Removal of impacted tooth, partially bony	Extractions	0%	50%	N/A
D7240	Removal of impacted tooth, completely bony	Extractions	0%	50%	N/A
D7241	Removal impacted tooth, complete bony, complication	Extractions	0%	50%	N/A
D7250	Removal of residual tooth roots (cutting procedure)	Extractions	0%	50%	N/A
D7260	Oroantral fistula closure	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7260) per site in a lifetime
D7261	Primary closure of a sinus perforation	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7261) per site in a lifetime
D7270	Tooth reimplantation and/or stabilization, accident	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7270) per tooth in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D7280	Exposure of an unerupted tooth	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7280) per tooth in a lifetime
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7285) per site every 2 calendar years
D7286	Incisional biopsy of oral tissue, soft	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7286) per site every 2 calendar years
D7288	Brush biopsy, transepithelial sample collection	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7288) per site every 2 calendar years
D7310	Alveoloplasty with extractions, four or more teeth per quadrant	Other Oral/Maxillofacial Surgery	0%	50%	1 of (D7310-D7321) per site quad in a lifetime
D7311	Alveoloplasty with extractions, one to three teeth per quadrant	Other Oral/Maxillofacial Surgery	0%	50%	1 of (D7310-D7321) per site quad in a lifetime
D7320	Alveoloplasty, w/o extractions, four or more teeth per quadrant	Other Oral/Maxillofacial Surgery	0%	50%	1 of (D7310-D7321) per site quad in a lifetime
D7321	Alveoloplasty, w/o extractions, one to three teeth per quadrant	Other Oral/Maxillofacial Surgery	0%	50%	1 of (D7310-D7321) per site quad in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7340) per site/quad in a lifetime
D7350	Vestibuloplasty, ridge extension	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7350) per site/quad in a lifetime
D7410	Excision of benign lesion, up to 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7411	Excision of benign lesion, greater than 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7412	Excision of benign lesion, complicated	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7413	Excision of malignant lesion, up to 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7414	Excision of malignant lesion, greater than 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7415	Excision of malignant lesion, complicated	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7440	Excision of malignant tumor, up to 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7441	Excision of malignant	Other Oral/Maxillofacial Surgery	0%	50%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	tumor, greater than 1.25 cm				
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7465	Destruction of lesion(s) by physical or chemical method, by report	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7471	Removal of lateral exostosis, maxilla or mandible	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7471) per arch in a lifetime

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D7472	Removal of torus palatinus	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7472) in a lifetime
D7473	Removal of torus mandibularis	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7473) in a lifetime
D7485	Reduction of osseous tuberosity	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7485) per site/quad in a lifetime
D7510	Incision & drainage of abscess, intraoral soft tissue	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7520	Incision & drainage of abscess, extraoral soft tissue	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7530	Remove foreign body, mucosa, skin, tissue	Other Oral/Maxillofacial Surgery	0%	50%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Other Oral/Maxillofacial Surgery	0%	50%	N/A
D7953	Bone replacement graft for ridge preservation, per site	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7953) per site in a lifetime
D7961	Buccal/labial frenectomy (frenulectomy)	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7961) per arch every 5 calendar years
D7962	Lingual frenectomy (frenulectomy)	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7962) every 5 calendar years
D7963	Frenuloplasty	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7963) every 5 calendar years
D7970	Excision of hyperplastic tissue, per arch	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7970) per arch every 5 calendar years
D7971	Excision of pericoronal gingiva	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7971) per tooth in a lifetime
D7972	Surgical reduction of fibrous tuberosity	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7972) per quad in a lifetime
D7997	Appliance removal (not by dentist who placed appliance), includes	Other Oral/Maxillofacial Surgery	0%	50%	1 (D7997) every 5 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	removal of archbar				
D9110	Palliative treatment of dental pain, per visit	Other Services	0%	50%	2 (D9110) every calendar year
D9222	Deep sedation/general anesthesia, first 15 minute increment	Other Services	0%	50%	N/A
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	Other Services	0%	50%	N/A
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	Other Services	0%	50%	N/A
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	Other Services	0%	50%	N/A
D9310	Consultation, other than	Other Services	0%	50%	N/A

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
	requesting dentist				
D9410	House/extended care facility call	Other Services	0%	50%	N/A
D9610	Therapeutic parenteral drug, single administration	Other Services	0%	50%	N/A
D9910	Application of desensitizing medicament	Other Services	0%	50%	1 (D9910) every calendar year
D9911	Application of desensitizing resin for cervical, root surface, per tooth	Other Services	0%	50%	1 (D9911) per tooth every calendar year
D9930	Treatment of complications, post surgical, unusual, by report	Other Services	0%	50%	N/A
D9942	Repair and/or reline of occlusal guard	Other Services	0%	50%	1 (D9942) every calendar year
D9944	Occlusal guard, hard appliance, full arch	Other Services	0%	50%	1 of (D9944-D9946) every 3 calendar years
D9945	Occlusal guard, soft appliance, full arch	Other Services	0%	50%	1 of (D9944-D9946) every 3 calendar years
D9946	Occlusal guard, hard appliance, partial arch	Other Services	0%	50%	1 of (D9944-D9946) every 3 calendar years

Code	Description of Benefit	Service	In-Network You Pay	Out-of-Network You Pay	Frequency/ Limitations
D9950	Occlusion analysis, mounted case	Other Services	0%	50%	N/A
D9951	Occlusal adjustment, limited	Other Services	0%	50%	1 of (D9951, D9952) every 2 calendar years
D9952	Occlusal adjustment, complete	Other Services	0%	50%	1 of (D9951, D9952) every 2 calendar years
D9995	Teledentistry, synchronous; real-time encounter	Other Services	0%	50%	2 of (D9995, D9996) every calendar year
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	Other Services	0%	50%	2 of (D9995, D9996) every calendar year

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

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

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

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

You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.

Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).

Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).

Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (**mvphealthcare.com**), and/or call the MVP Medicare Customer Care Center.

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from the MVP Medicare Customer Care Center or use the *Pharmacy Directory*. You can also find information on our website at **mvphealthcare.com**.

What if you need a specialized pharmacy?

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

Pharmacies that supply drugs for home infusion therapy.

Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact the MVP Medicare Customer Care Center.

Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.

Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call the MVP Medicare Customer Care Center.

Section 2.3 Using the plan's mail-order service

For certain kinds of drugs, you can use the plan's network mail-order service. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a

chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked with an "**NM"** in our "Drug List."

Our plan's mail-order service requires you to order*:* ***at least*** **a 30-day supply of the drug and** ***no more than*** **a 90-day supply**.

To get order forms and information about filling your prescriptions by mail contact the MVP Medicare Customer Care Center.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If you don't have a 14-day supply of your medication on hand, ask your doctor to give you a second prescription for a 30-day supply, and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call the MVP Medicare Customer Care Center. We will work with you to make sure you have your medications when you need them.

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

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by contacting CVS/Caremark at 1-866-494-8829 (calls to this number are free).

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

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling CVS/Caremark Customer Service at 1-866-494-8829 (calls to this number are free).

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

Refills on mail-order prescriptions. For refills, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

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

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

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

Your prescription may be covered in certain situations

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

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

Generally, you should only use an out-of-network pharmacy in limited situations. You may use a non-network pharmacy when a network pharmacy is not available or if you are trying to fill a covered prescription drug that is not regularly stocked at an in-network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

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

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

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

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

Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.

-- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug List" includes brand name drugs and generic drugs."

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work just as well as the brand name drug and usually cost less. There are generic drug substitutes available for many brand name drugs

What is *not* on the "Drug List?"

The plan does not cover all prescription drugs.

In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).

In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the "Drug List." For more information, please see Chapter 9.

Section 3.2 There are 5 cost-sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Tier 1 – Preferred Generic Drugs** – Includes select generic drugs used to treat chronic conditions in the lowest cost-sharing tier.
- **Tier 2 – Generic Drugs** – Includes most other generic drugs on our Formulary.
- **Tier 3 – Preferred Brand Drugs** – Includes preferred brand-name drugs that have the lowest cost-sharing for brand-name drugs. Certain generic drugs may appear on Tier 3 due to potential safety concerns or the high cost of the drug.
- **Tier 4 – Non-Preferred Drugs** – Includes all other brand-name and generic drugs on our Formulary.
- **Tier 5 – Specialty Drugs** – Includes high-cost specialty generic and brand-name drugs. This is the highest cost-sharing tier.

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

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

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

You have 4 ways to find out:

1. Check the most recent "Drug List" we provided electronically. (Please note: The "Drug List" we provide includes information for the covered drugs that

are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact the MVP Medicare Customer Care Center to find out if we cover it.)

2. Visit the plan's website (**mvphealthcare.com**). The "Drug List" on the website is always the most current.
3. Call the MVP Medicare Customer Care Center to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (Go to Caremark.com, click the Register button and follow the instructions to sign up or by calling the MVP Medicare Customer Care Center). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

Section 4.2 What kinds of restrictions?

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

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

Restricting brand name drugs when a generic version is available

Generally, a **generic** drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

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

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

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

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

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

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

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

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

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

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call the MVP Medicare Customer Care Center.

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

1) You can change to another drug

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

2) You can ask for an exception

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

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

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

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

You can change to another drug

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

You can ask for an exception

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

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

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

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

Section 6.1 The "Drug List" can change during the year

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

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

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

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

Information on changes to drug coverage

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

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

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List," but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.

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

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

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

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

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

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

Section 7.1 Types of drugs we do not cover

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

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

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

Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. **Off-label** use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

  Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

In addition, if you are **receiving "Extra Help" from Medicare** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's "Drug List" or call the MVP Medicare Customer Care Center for more information. Phone numbers for the MVP Medicare Customer Care Center are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

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

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

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

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

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

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

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

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

Special note about creditable coverage:

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

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

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

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

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

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a

pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

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

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

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

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

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

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you

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

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

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

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

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

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

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling the MVP Medicare Customer Care Center.

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

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

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.

- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

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

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

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

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

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

It matters who pays:

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

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stageto the Catastrophic Coverage Stage.

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

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

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

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

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for MVP Medicare WellSelect with Part D (PPO) members?

There are four **drug payment stages** for your prescription drug coverage under MVP Medicare WellSelect with Part D (PPO). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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

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

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. The Part D EOB includes:

Information for that month. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

Totals for the year since January 1. This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.

Drug price information. This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.

Available lower cost alternative prescriptions. This will include information about other available drugs with lower cost sharing for each prescription claim.

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

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

Show your membership card every time you get a prescription filled. This helps us make sure we know about the prescriptions you are filling and what you are paying.

Make sure we have the information we need. There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at the MVP Medicare Customer Care Center. Be sure to keep these reports.

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

The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of $250 on tier 3-5 drugs. **You must pay the full cost of your tier 3-5 drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid $250 for your tier 3-5drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

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

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

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

The plan has 5 cost-sharing tiers

Every drug on the plan's "Drug List" is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1 – Preferred Generic Drugs** – Includes select generic drugs used to treat chronic conditions in the lowest cost-sharing tier.
- **Tier 2 – Generic Drugs** – Includes most other generic drugs on our Formulary.
- **Tier 3 – Preferred Brand Drugs** – Includes preferred brand-name drugs that have the lowest cost-sharing for brand-name drugs. Certain generic drugs may appear on Tier 3 due to potential safety concerns or the high cost of the drug.
- **Tier 4 – Non-Preferred Drugs** – Includes all other brand-name and generic drugs on our Formulary.
- **Tier 5 – Specialty Drugs** – Includes high-cost specialty generic and brand-name drugs. This is the highest cost-sharing tier.

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

Your pharmacy choices

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

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

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

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

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

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

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

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

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic drugs)	$0 copay	$0 copay	$0 copay	$0 copay plus any differential costs from in-network
Cost-Sharing Tier 2 (Generic drugs)	$12 copay	$12 copay	$12 copay	$12 copay plus any differential costs from in-network
Cost-Sharing Tier 3 (Preferred Brand name drugs)	$47 Copay	$47 Copay	$47 Copay	$47 Copay plus any differential costs from in-network
Cost-Sharing Tier 4 (Non-Preferred drugs)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance plus any differential costs from in-network
Cost-Sharing Tier 5 (Specialty drugs)	27% coinsurance	27% coinsurance	27% coinsurance	27% coinsurance plus any differential costs from in-network

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

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

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

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

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

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

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

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

Tier	**Standard retail cost sharing (in-network)** (90-day supply)	**Mail-order cost sharing** (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic drugs))	$0 copay	$0 copay
Cost-Sharing Tier 2 (Generic drugs)	$36 copay	$24 copay
Cost-Sharing Tier 3 (Preferred Brand name drugs)	$141 copay	$94 copay
Cost-Sharing Tier 4 (Non-Preferred drugs)	25% coinsurance	25% coinsurance
Cost-Sharing Tier 5 (Specialty drugs)	A long-term supply is not available for drugs in Tier 5.	Mail order is not available for drugs in Tier 5.

You won't pay more than $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach out-of-pocket costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.

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

SECTION 6 Costs in the Coverage Gap Stage

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

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

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

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Refer to your plan's "Drug List" or contact the MVP Medicare Customer Care Center for coverage and cost sharing details about specific vaccines.

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

The first part of coverage is the cost of **the vaccine itself**.

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

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

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee or Immunization Practices (ACIP).

- Most adult Part D vaccinations are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.

Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

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

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

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.

- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration) ,and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.
- and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

CHAPTER 7:

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

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

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

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

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

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

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

   - If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.

- If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

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

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

3. If you are retroactively enrolled in our plan

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

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

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

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

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

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

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

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

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

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 1 year** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster.
  To ensure prompt processing of your claim, bills submitted must include the following (contact your provider to obtain any additional information):
    - o The name and address of the provider (on letterhead) of the service or supply (e.g., doctor or hospital), including the Tax ID and NPI numbers.
    - o The patient's full name and health plan identification number.
    - o HCPCS or CPT Code(s) for the type of service provided (e.g., office visit, chest x-ray).
    - o Place of service (e.g., inpatient or outpatient hospital, office).
    - o Date and charge for each service or supply provided.
    - o ICD-CM code for the medical condition for which the patient was treated (e.g., routine exam, cough, hypertension).
- o If another insurance carrier has made payment on this service, an explanation of benefits from that carrier must be submitted with the claim. Either download a copy of the form from our website (**mvphealthcare.com**) or call the MVP Medicare Customer Care Center and ask for the form.

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

For Medical claims:
MVP Health Care
P.O. Box 2207

Schenectady, NY 12301

For Prescription drug claims:
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

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

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

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

If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:
Your rights and responsibilities

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

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

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

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with the MVP Medicare Customer Care Center (phone numbers are printed on the back cover of this booklet)You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, tells what you can do.

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

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

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

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

How do we protect the privacy of your health information?

We make sure that unauthorized people don't see or change your records.

Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*

There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- We are required to release health information to government agencies that are checking on quality of care.

- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

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

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

As a member of MVP Medicare WellSelect with Part D (PPO) , you have the right to get several kinds of information from us.

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

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

- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

Information about your coverage and the rules you must follow when using your coverage. Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.

Information about why something is not covered and what you can do about it. Chapter 9 provides information on asking for a written explanation on

why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

To know about all of your choices. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

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

Get the form. You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact the MVP Medicare Customer Care Center to ask for the forms.

Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with New York State Department of Health at 1-800-206-8125.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint - **we are required to treat you fairly.**

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

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

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

Is it about something else?

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

You can **call the MVP Medicare Customer Care Center**.

You can **call the SHIP**. For details, go to Chapter 2, Section 3.

Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

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

You can **call the MVP Medicare Customer Care Center**.

You can **call the SHIP**. For details, go to Chapter 2, Section 3.

You can contact **Medicare**.

You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.

  If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**

If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can also visit the Medicare website (www.medicare.gov).

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a

favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

You **can call us at the MVP Medicare Customer Care Center**.

You **can get free help** from your State Health Insurance Assistance Program.

Your doctor can make a request for you. If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call the MVP Medicare Customer Care Center and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)

- For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or other person to be your representative, call the MVP Medicare Customer Care Center and ask for the *Appointment of*

Representative form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **mvphealthcare.com**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

You also have the right to hire a lawyer. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
- **Section 7** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 8** of this chapter: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call the MVP Medicare Customer Care Center. You can also get help or information from government organizations such as your SHIP.

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

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

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

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility

(CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

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

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

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

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

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

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

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

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

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

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe
A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

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

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

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

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

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

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may

include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization

decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.). In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

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

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

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

Part D coverage decisions and appeals

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

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

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

- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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

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

Section 6.2 What is an exception?

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

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

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

1. **Covering a Part D drug for you that is not on our "Drug List."** If we agree to cover a drug not on the "Drug List," you will need to pay the cost-sharing amount that applies to drugs in Tier 4 (Non-Preferred drugs). You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List." If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug List" is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty drugs).
   - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request, you can ask for another review by making an appeal.

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

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

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.

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

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

You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.
If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.

- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

We must give you our answer **within 14 calendar days** after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

<u>Step 4:</u> If we say no to your coverage request, you can make an appeal.

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

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

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

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

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

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

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

For standard appeals, submit a written request or call us. Chapter 2 has contact information.

For fast appeals either submit your appeal in writing or call us at 1-800-665-7924. Chapter 2 has contact information.

We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

You can ask for a copy of the information in your appeal and add more information. You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.

- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization Section 6.6 explains the Level 2 appeal process.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.

If our answer is yes to part or all of what you requested, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

We must give you our answer **within 14 calendar days** after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

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

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

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

We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

If your health requires it, ask the independent review organization for a fast appeal.

If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

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

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

For fast appeals:

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

For standard appeals:

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

What if the review organization says no to your appeal?

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

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

<u>Step 4:</u> If your case meets the requirements, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged you too soon

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

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

The day you leave the hospital is called your **discharge date**.

When your discharge date is decided, your doctor or the hospital staff will tell you.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

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

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

   Your right to be involved in any decisions about your hospital stay.

   Where to report any concerns you have about quality of your hospital care.

Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**

   You or someone who is acting on your behalf will be asked to sign the notice.

   Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

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

   If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.

   To look at a copy of this notice in advance, you can call the MVP Medicare Customer Care Center or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling the MVP Medicare Customer Care Center or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 7.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

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

You can appeal to us instead

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

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

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

<u>Step 1:</u> Contact us and ask for a fast review.

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

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

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

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

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

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

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

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

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

<u>Step 1:</u> We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 8.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 8.2 We will tell you in advance when your coverage will be ending

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
- The date when we will stop covering the care for you.
- How to request a fast track appeal to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

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

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Step 1:</u> We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

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

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

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

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

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

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

If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.

- If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

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

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

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

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

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

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

If the answer is yes, the appeals process is over. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

If the answer is no, the appeals process *may* or *may not* be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

If the answer is yes, the appeals process is over. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

If the answer is no, the appeals process *may* or *may not* be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

MAKING COMPLAINTS

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

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with the MVP Medicare Customer Care Center? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by the MVP Medicare Customer Care Center or other staff at the 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?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical 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 10.2 How to make a complaint

Legal Terms

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

Section 10.3 Step-by-step: Making a complaint

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

Usually, calling the MVP Medicare Customer Care Center is the first step. If there is anything else you need to do, the MVP Medicare Customer Care Center will let you know.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

If you have a complaint, you or your representative may call the phone number listed in Chapter 2. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or if your complaint is related to quality of care, we will respond in writing to you within 30 days. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this a grievance procedure.

The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call.

Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you **an answer within 24 hours**.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

You can make your complaint directly to the Quality Improvement Organization.

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

Or

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

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about MVP Medicare WellSelect with Part D (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MVP Medicare WellSelect with Part D (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.

- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

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

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

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

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

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

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

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

During the annual Medicare Advantage Open Enrollment Period you can:

- Switch to another Medicare Advantage Plan with or without prescription drug coverage.
- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

In certain situations, members of MVP Medicare WellSelect with Part D (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.

- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

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

The enrollment time periods vary depending on your situation.

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

Another Medicare health plan with or without prescription drug coverage.

Original Medicare *with* a separate Medicare prescription drug plan.

OR

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

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

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

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

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

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

- **Call the MVP Medicare Customer Care Center**.
- Find the information in the ***Medicare & You 2024*** handbook.

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

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

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

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

Continue to use our network providers to receive medical care.

Continue to use our network pharmacies *or mail order* to get your prescriptions filled

If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5 MVP Medicare WellSelect with Part D (PPO) must end your membership in the plan in certain situations

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

MVP Medicare WellSelect with Part D (PPO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call the MVP Medicare Customer Care Center to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
    - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.

If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call the MVP Medicare Customer Care Center.

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

MVP Medicare WellSelect with Part D (PPO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

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

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, MVP Medicare WellSelect with Part D (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary

exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 12:
Definitions of important words

Allowed Amount - The maximum amount of the billed charge that is determined to be payable by the plan for covered services.

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

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

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

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

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

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services.

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

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

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need

to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

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

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

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

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

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

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

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

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating

devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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

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

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

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

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

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

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

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

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

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

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

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

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

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

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

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

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

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

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

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

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

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

Medicare 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 Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the

Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

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

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

Prescription Drug Benefit Manager (PBM) – A third party administrator of prescription drug programs responsible for developing and maintaining the Plan's Formulary, processing and paying claims, contracting with network pharmacies, and negotiating cost with manufacturers.

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

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

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

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

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

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

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

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

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

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

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

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

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

MVP Medicare WellSelect with Part D (PPO) MVP Medicare Customer Care Center

Method	The MVP Medicare Customer Care Center – Contact Information
CALL	1-800-665-7924 Calls to this number are free. MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time. the MVP Medicare Customer Care Center also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. MVP Medicare Customer Care Center Representatives are available to serve you: Call us seven days a week from 8 am-8 pm Eastern Time. From April 1 – September 30, call us Monday – Friday from 8 am-8 pm Eastern Time.
FAX	585-327-2298
WRITE	MVP Health Care 20 S. Clinton Ave Rochester, NY 14604
WEBSITE	mvphealthcare.com

HIICAP

HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Health Insurance Information Counseling and Assistance Program (HIICAP) (New York SHIP) – Contact Information
CALL	1-800-701-0501
TTY	You may call the number above to find the address for your local HIICAP counselor.
WEBSITE	www.aging.ny.gov

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