The Catholic Diocese of Cleveland - Priests

Group Number – 815903

2027 Evidence of Coverage

MedMutual Advantage PPO Plan

600882

This Evidence of Coverage includes information on standard rules and processes for a Medical Mutual Medicare Advantage plan. However, there may be situations where the plan rules as outlined here differ from those of your former employer or retiree group.

For plan-specific information, please be sure to review your other plan materials or contact Customer Care at 1-800-801-4823.

January 1 - December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of the MedMutual Advantage PPO Plan.

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

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

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

For questions about this document, call Customer Care at 1-800-801-4823. (TTY users call 711.) Hours are 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). This call is free.

This plan, *MedMutual Advantage PPO,* is offered by Medical Mutual of Ohio (Medical Mutual). (When this *Evidence of Coverage* says "we," "us," or "our," it means Medical Mutual. When it says "plan" or "our plan," it means *MedMutual Advantage PPO.)*

This document is available in alternate formats (e.g., braille, large print, audio).

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

Our formulary, pharmacy network, and/or provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of MedMutual Advantage PPO

Section 1.1 You're enrolled in MedMutual Advantage PPO, which is a Medicare PPO Plan

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, MedMutual Advantage PPO. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

MedMutual Advantage 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.

For information on plan changes that may be available during the Group Open Enrollment Period, contact your group's benefit administrator.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MedMutual Advantage PPO covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (formulary)*, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in MedMutual Advantage PPO between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of MedMutual Advantage PPO after December 31, 2027. We can also choose to stop offering our plan in your service area after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve MedMutual Advantage PPO each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews its approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- Your group's benefit administrator determines you are eligible. (For questions about your group's eligibility rules, please contact your group's benefit administrator.)
- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (describer in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- –You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for MedMutual Advantage PPO

MedMutual Advantage PPO is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes all 50 states. We offer coverage in all states and U.S. territories.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Care at 1-800-801-4823 (TTY users call 711) to see if we have a plan in your new area.

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

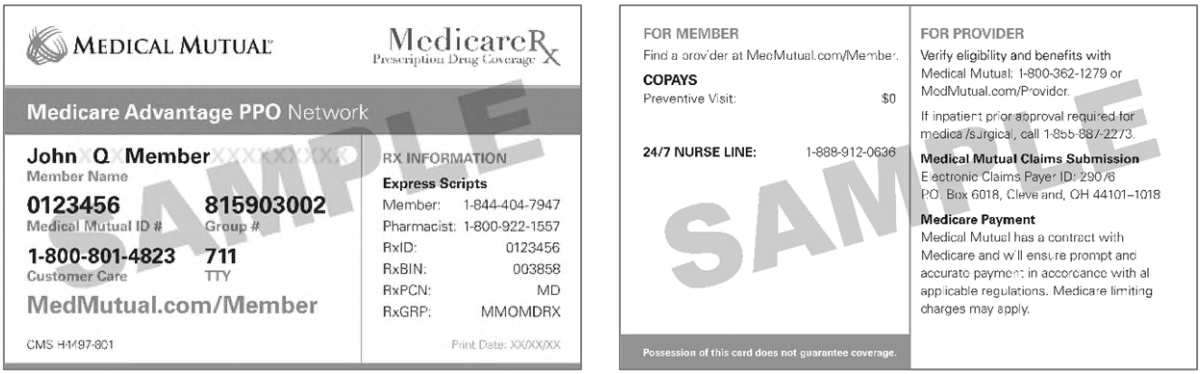
Section 2.3 U.S. Citizen or national, eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify MedMutual Advantage PPO if you're not eligible to stay a member of our plan on this basis. MedMutual Advantage PPO must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your MedMutual Advantage 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 our plan membership card is damaged, lost, or stolen, call Customer Care at 1-800-801-4823 (TTY users call 711) right away and we'll 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 get 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. Go to Chapter 3 for more specific information.

If you need to seek covered services from providers who are outside Ohio (in other words, from an out-of-network provider), your plan provides in-network coverage for these services, but only if the provider is eligible to participate in Medicare. To find a provider when you are outside Ohio, call Customer Care at 1-800-801-4823 or use the provider search tool at medicare.gov.

Get the most recent list of providers and suppliers on our website at MedMutual.com/MAgroup.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or paper form) from Customer Care. Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

The *Pharmacy Directory* (MedMutual.com/MAgroup) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

The *Pharmacy Directory* also shows which pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Customer Care at 1-800-801-4823 (TTY users call 711) You can also find this information on our website at MedMutual.com/MAgroup.

Section 3.4 Drug List (formulary)

Our plan has a List of Covered Drugs (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in MedMutual Advantage PPO. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the MedMutual Advantage PPO Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit MedMutual.com/MAgroup or call Customer Care at 1-800-801-4823 (TTY users call 711).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium	Your plan is offered through a retiree group. If you owe a plan premium, your retiree group will let you know the amount you owe and how to pay.
Deductible	**$125** for hearing aid batteries
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details.)	From in-network providers: **$1,000** From network and out-of-network providers combined: **$1,000**
Primary care office visits	**There is no coinsurance, copayment, or deductible** per visit
Specialist office visits	**There is no coinsurance, copayment, or deductible** per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**Day 1 and thereafter:** There is no coinsurance, copayment, or deductible
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible: $0** **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** **Preferred** network pharmacies • **$0 copayment** per prescription for up to a 30-day supply (retail or mail order) **Standard** network pharmacies • **$10 copayment** per prescription for up to a 30-day supply (retail or mail order) **Drug Tier 2:** **Preferred** network pharmacies • **$5 copayment** per prescription for up to a 30-day supply (retail or mail order) **Standard** network pharmacies • **$10 copayment** copay per prescription for up to a 30-day supply (retail or mail order) **Drug Tier 3:** **Preferred** network pharmacies • **15% coinsurance ($20 min./$70 max.)**

	Your Costs in 2027
	per prescription for up to a 30-day supply (retail or mail order) **Standard** network pharmacies • **20% coinsurance ($25 min./$75 max.)** for up to a 30-day supply (retail or mail order) *You pay no more than $35 per month supply of each covered insulin product on this tier.* **Drug Tier 4:** **Preferred** network pharmacies • **35% coinsurance ($35 min./$145 max.)** per prescription for up to a 30-day supply (retail or mail order) **Standard** network pharmacies • **40% coinsurance ($40 min./$150 max.)** for up to a 30-day supply (retail or mail order) *You pay no more than $35 per month supply of each covered insulin product on this tier.* **Drug Tier 5:** **Preferred** network pharmacies • **35% coinsurance ($35 min./$145 max.)** per prescription for up to a 30-day supply **Standard** network pharmacies • **40% coinsurance ($40 min./$150 max.)** per prescription for up to a 30-day supply **Drug Tier 6:** **Preferred** network pharmacies • **$0 copayment** per prescription for up to a 30-day supply (retail or mail order) **Standard** network pharmacies • **$10 copayment** per prescription for up to a 30-day supply (retail or mail order) **Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs.

Your costs can 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)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

Your coverage is provided through a contract with your current employer or former employer. See the premium information in the chart above.

Section 4.2 Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

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

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 was a period of 63 days or more in a row when you didn't 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 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'll generally have to pay this penalty for as long as you have Part D coverage.

If you are required to pay a late enrollment penalty, your group will inform you of the amount that you will be required to pay and how to pay. The Part D late enrollment penalty may be added to your monthly premium. When you first enroll in MedMutual Advantage PPO, your group will let you know the amount of the penalty. Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.
- You have had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's 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, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year(national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, 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 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 reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a reconsideration 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 (IRMAA). The extra charge is calculated 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 Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, 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'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our 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 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 Keep your plan membership record up to date

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

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

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

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

If any of this information changes, contact your group's benefit administrator, or if so directed by that administrator, Customer Care at 1-800-801-4823 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security in Chapter 2, Section 5.

SECTION 6 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage that we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, please call Customer Care at 1-800-801-4823 (TTY users call 711). 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), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary

payer"), pays up to the limits of its coverage. The insurance that pays second (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

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

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 MedMutual Advantage PPO contacts

For help with claims, billing, or member card questions, call or write to MedMutual Advantage PPO Customer Care. We'll be happy to help you.

Customer Care – Contact Information	
Call	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Customer Care (1-800-801-4823 (TTY users call 711)) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
Write	Medical Mutual Attn: Customer Care P.O. Box 94563 Cleveland, OH 44101-4563
Website	MedMutual.com/MAgroup

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. 1-855-887-2273 to request an expedited organization determination or expedited appeal only. Available Monday through Friday, 8 a.m. to 5 p.m.

Coverage Decisions and Appeals for Medical Care – Contact Information		
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).	
Fax	1-844-606-5394 for standard appeals 1-800-221-2640 for expedited organization determinations or expedited ("fast track") appeals only	
Write	<u>For coverage determinations:</u> Medical Mutual MZ 02-3P-7516 100 American Road Cleveland, OH 44144-2322 <u>For appeals:</u> Medical Mutual Attn: Medicare Advantage Appeals & Grievances Department P.O. Box 94563 Cleveland, OH 44101-4563	<u>For expedited determinations:</u> Medical Mutual Attn: Medicare Care Management MZ 02-3P-3982 100 American Road Cleveland, OH 44144-2322
Website	MedMutual.com/Member For appeals: Log in to My Health Plan, and select "Resources & Tools" and then "Forms."	

Coverage Decisions and Appeals for Part D drugs – Contact Information		
Call	1-800-935-6103 Calls to this number are free and can be made 24 hours a day, 7 days a week, 365 days a year.	
TTY	1-800-716-3231 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free and can be made 24 hours a day, 7 days a week, 365 days a year.	
Fax	For coverage decisions: 1-877-251-5896 For appeals: 1-877-852-4070	
Write	<u>For coverage decisions:</u> Express Scripts Attn: Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571	<u>For appeals:</u> Express Scripts Attn: Medicare Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
Website	MedMutual.com/MAgroup	

How to make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care or Part D drugs – Contact Information	
Call	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
Fax	1-844-606-5394
Write	Medical Mutual Attn: Medicare Advantage Appeals & Grievances Department P.O. Box 94563 Cleveland, OH 44101-4563
Medicare website	To submit a complaint about MedMutual Advantage PPO directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay for our share of the cost for medical care or a drug you got
If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information		
Fax	For Part D (prescription drug) claims only: 1-608-741-5483	
Write	For Part C (medical) claims: Medical Mutual P.O. Box 6018 Cleveland, OH 44101-1018	For Part D (prescription drug) claims: Express Scripts Attn: Medicare Part D P.O. Box 52023 Phoenix, AZ 85072
Website	MedMutual.com/MAgroup	

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about MedMutual Advantage PPO. **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Please see Appendix 1 to find the SHIP for your state.

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

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

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state and U.S. territory. Please see below for your state or territory's Quality Improvement Organization.

Each Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Quality Improvement Organizations are independent organizations. It's not connected with our plan.

Contact your Quality Improvement Organization in any of these situations:

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

Acentra Health is the Quality Improvement Organization for the following states and territories: Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, and Wyoming.

Acentra Health Contact Information TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.	
Region 1: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	
Address/Website	
Acentra Health 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 AcentraQIO.com	1-888-319-8452 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	
Address/Website	**Phone**
Acentra Health 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 AcentraQIO.com	1-888-317-0751 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available. TTY 1-855-843-4776
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas	
Address/Website	**Phone**
Acentra Health 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609 AcentraQIO.com	1-888-315-0636 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776

Acentra Health Contact Information
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

Address/Website	Phone
Acentra Health 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 AcentraQIO.com	1-888-317-0891 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776

Region 10: Alaska, Idaho, Oregon, Washington

Address/Website	Phone
Acentra Health 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131 AcentraQIO.com	1-888-305-6579 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) 24-hour voicemail service is available TTY 1-855-843-4776

Commence Health is the Quality Improvement Organization for the following states and territories: Arizona, California, Delaware, District of Columbia, Hawaii, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, Ohio, Pacific Territories, Pennsylvania, Puerto Rico, U.S. Virgin Islands, Virginia, West Virginia, and Wisconsin.

Commence Health Contact Information
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.

Region 2: New Jersey, New York, Puerto Rico, U.S. Virgin Islands

Address/Website	Phone
BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov	1-866-815-5440 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 10:00 a.m. - 4:00 p.m. (local time) 24-hour voicemail service is available TTY 711

Region 3: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

Address/Website	Phone
BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov	1-888-396-4646 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 10:00 a.m. - 4:00 p.m. (local time) 24-hour voicemail service is available TTY 711

Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Address/Website	Phone
BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov	1-888-524-9900 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 10:00 a.m. - 4:00 p.m. (local time) 24-hour voicemail service is available TTY 711

Commence Health Contact Information TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.	
Region 7: Iowa, Missouri, Kansas, Nebraska	
Address/Website	**Phone**
BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov	1-888-755-5580 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 10:00 a.m. - 4:00 p.m. (local time) 24-hour voicemail service is available TTY 711
Region 9: Arizona, California, Hawaii, Nevada, Pacific Territories (American Samoa, Guam, Northern Mariana Islands)	
Address/Website	**Phone**
BFCC-QIO Program Commence Health P.O. Box 2687 Virginia Beach, VA 23450 commencehealthqio.cms.gov	1-877-588-1123 Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Saturday-Sunday: 10:00 a.m. - 4:00 p.m. (local time) 24-hour voicemail service is available TTY 711

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment . Social Security is also responsible for determining who has to pay an extra amount for 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, contact Social Security to let them know.

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

SECTION 6 Medicaid

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

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

To find out more about Medicaid and Medicare Savings Programs, contact your state department of Medicaid, listed in Appendix 2.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare
Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply at any time. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence, of the right amount, we can help you share this evidence with us.

- To request assistance or to provide evidence, please call us at the numbers listed in Section 1 of this chapter.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Care at 1-800-801-4823 (TTY users call 711) if you have questions.

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands,

and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about its rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for more information. TTY users call 1-877-486-2048. You can also visit Medicare.gov for more information.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have "Extra Help" and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access to life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP operating in your state. See Appendix 3 for a list of the AIDS Drug Assistance Programs in each state we serve.

Note: To be eligible for the ADAP in your state, people 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 get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the ADAP in your state.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help 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. See Appendix 4 for a list of the State Pharmaceutical Assistance Programs in each state we serve.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call Customer Care at 1-800-801-4823 (TTY users call 711) or visit Medicare.gov.

Medicare Prescription Payment Program – Contact Information	
Call	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Customer Care (1-800-801-4823 (TTY users call 711)) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
Write	Medical Mutual Attn: Customer Care P.O. Box 94563 Cleveland, OH 44101-4563
Website	Medicare.gov

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you 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.

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

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Care at 1-800-801-4823 (TTY users call 711) with any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3:
Using our plan for your medical services

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

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

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

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We 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 Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, MedMutual Advantage PPO must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

MedMutual Advantage PPO will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** (in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider won’s eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider Directory* (MedMutual.com/MAgroup).
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - 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 can’t pay a provider who isn’t eligible to participate in Medicare. If you go to a provider who isn’t eligible to participate in Medicare, you’ll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they’re eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get 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?

1. A PCP is your Primary Care Physician. When you become a member of our plan, you will be asked to select a network physician to be your PCP. A PCP is a physician who meets state requirements and is trained to give you basic medical care. He or she is generally most familiar with your medical condition and history. Your PCP may also coordinate the rest of the covered services you get as a plan member, but you do not need to get a referral from your PCP to see other network physicians.
2. What types of providers may act as a PCP?
   PCPs are generally physicians specializing in internal medicine, family practice, general practice or geriatric medicine.
3. What is the role of my PCP?
   Your relationship with your PCP is important, because your PCP is responsible for routine health care needs and may help coordinate your covered services. Coordinating your services includes consulting with other providers about your care and how it is progressing.

How to choose a PCP

When you become a member of our plan, we will ask you to choose a network provider to be your PCP when you fill out your enrollment application. You can use our *Provider Directory* to select your PCP or you may contact Customer Care.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP or you'll pay more for covered services. Be aware that changing your PCP may result in your being limited to specific hospitals with which your PCP has admitting privileges.

To change your PCP, simply call Customer Care. You can also change your PCP by visiting our secure member site at MedMutual.com/Member.

If the new PCP is accepting new members, the transfer will become effective on the day we receive your request.

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

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

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

You do not need a referral to see specialists or other network providers. However, we encourage you to first see your PCP, if you have selected one. Your PCP can help coordinate your health care needs with specialists and other providers. In addition, certain services require prior authorization (PA) from the plan. Your provider is responsible for obtaining this prior authorization.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization may apply. Please contact Customer Care for more information.
- If you find out that your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to our plan, or both(go to Chapter 9).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. 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 when you receive services, your share of the costs for covered services may be higher. Here are more 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 can't pay a provider who isn't eligible to participate in Medicare. If you receive care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary(go to Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll 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(go to Chapter 7*)*.
- If you're 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(go to Section 3).
- When you are outside our network area or outside Ohio and need to obtain covered services, your plan provides in-network coverage for these services, but only if the provider is eligible to participate in Medicare. To find a provider, call Customer Care at 1-800-801-4823 (TTY users call 711) or use the provider search tool at medicare.gov.

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You 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're not part of our network. This coverage is worldwide.
- **As soon as possible, make sure 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. Please contact our Care Management department toll free at 1-855-887-2273 between the hours of 8 a.m. and 5 p.m., Monday through Friday. If calling at other times, please leave a voice message.

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

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

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

If you get your follow-up care from out-of-network providers, you'll 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, 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 Get care when you have an urgent need for services

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

You can receive in-network coverage for plan-covered services from a provider who is eligible to participate in Medicare.

When urgent care is needed and network providers are temporarily unavailable or inaccessible, proceed to the nearest urgent care center for immediate treatment. You can find in-network urgent care centers in our *Provider Directory* by going to MedMutual.com/MAgroup or by calling Customer Care at 1-800-801-4823.

You can also call our Nurse Line toll free at 1-888-912-0636 to speak with a registered nurse who can answer your questions or direct you to the appropriate next step. Our nurses are available 24 hours per day, 7 days per week for advice.

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: You're traveling outside the United States for less than six months. **For coverage under your plan benefits, you must get care from a hospital or urgent care facility, and supply documentation for reimbursement following the instructions in Chapter 7, Section 2.** Required documentation for worldwide emergency or urgent care claims include:

- Medical records (translated into English, if possible), and
- Itemized claim(s) OR detailed receipt(s) from the facility, including date(s) of service and detailed description of the diagnosis and services rendered.

Go to "Emergency care" and "Urgently needed services" in the Medical Benefits Chart in Chapter 4 for more details.

Section 3.3 Get care during a disaster

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

Visit MedMutual.com/MAgroup for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

MedMutual Advantage PPO covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Any costs you pay after a benefit limit has been reached will not count toward your out-of-pocket maximum for services over the limit.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

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

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

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

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution?

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

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

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

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

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

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

Medicare Inpatient Hospital coverage limits apply (go to the *Medical Benefits Chart* in Chapter 4).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of MedMutual Advantage 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 Customer Care for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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

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

Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, MedMutual Advantage 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 MedMutual Advantage 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 with 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 applicable cost sharing 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's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of MedMutual Advantage PPO. This section also gives information about medical services that aren't covered and explains limits on certain services.

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

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

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our plan deductible.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits tells you more about your coinsurance.)

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

Section 1.2 Our plan has a deductible for certain types of services from in-network and out-of-network providers

Your deductible is $125 for hearing aid batteries. Until you've paid the deductible amount, you must pay the full cost for hearing aid batteries. Once you have paid your deductible, we'll pay our share of the costs for these services, and you'll pay your share.

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services.

- Your **in-network maximum out-of-pocket amount (MOOP)** is **$1,000**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for deductibles, 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 drugs, and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart). If you pay $1,000 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is **$1,000**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $1,000 for covered services, you'll 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 your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

As a member of MedMutual Advantage PPO, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Care at 1-800-801-4823 (TTY users call 711).

SECTION 2 The Medical Benefits Chart

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

The Medical Benefits Chart on the following pages lists the services MedMutual Advantage 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 Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- 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).
  - Covered services that need approval in advance to be covered as in-network services are marked in bold in the Medical Benefits Chart. These services not listed in the Medical Benefits Chart require approval in advance:
    - Artificial Heart Systems
    - Artificial Limbs and Prosthetic Devices
    - Bone Growth Stimulators
    - Carotid Artery Stenting
    - Cochlear Implant
    - Electrical Stimulation and Electromagnetic Therapy for Ulcers
    - Genetic Testing
    - Hyperbaric Therapy
    - Lumbar Spinal Fusion
    - Transcatheter Valve Replacement/Implantation
    - Transplants - Bone Marrow, Organs and Stem Cell
    - Uterine Artery Embolization for Treatment of Fibroids
    - Varicose Vein: Surgical Treatment and Sclerotherapy
    - Ventricular Assist Devices
  - 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.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

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 get the services from:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates in Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at) Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

Important Benefit Information for People Who Qualify for Extra Help:

- If you get Extra Help to pay your Medicare drug coverage costs, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
For services that have member cost-sharing, providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: • Your doctor will ask for a copayment for the office visit and additional copayments for each x-ray that is performed while you are there. • Your hospital will ask for separate cost sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there. • Your pharmacist will ask for a separate copayment or coinsurance for each prescription he or she fills. • The specific cost sharing that will apply depends on which services you receive and how those services are billed by the provider. The Medical Benefits Chart below lists the cost sharing that applies for each specific service.	
Abdominal aortic aneurysm screening	**In Network and Out of Network** **There is no coinsurance, copayment, or**

Covered Service	What you pay
A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	**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 under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	Auxiliary personnel, such as chiropractors and acupuncturists, may perform acupuncture sessions for you as long as these sessions are supervised and billed by a physician who is currently treating you for chronic lower back pain. **In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered acupuncture service in a primary care physician's office. **There is no coinsurance, copayment, or deductible** for each covered acupuncture service in a specialist's office. **Prior authorization rules may apply. Please contact the plan for details.**
Allergy testing and treatment Your plan covers allergy testing and treatment	**In Network and Out of Network** **There is no coinsurance, copayment, or**

Covered Service	What you pay
performed and related to a specific diagnosis.	**deductible** for allergy testing. **There is no coinsurance, copayment, or deductible** for allergy treatment.
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for covered one-way ambulance services. **Prior authorization rules may apply. Please contact the plan for details.**
Annual in-home health assessment In addition to the annual physical exam and Medicare-covered annual wellness visit listed below, your plan also covers one annual in-home health assessment per calendar year. Intended as a complement to primary care, the assessment is conducted in your home (or by telehealth when appropriate) by a licensed clinician and focuses on a holistic evaluation of health and care needs, including medical history, medication review, functional status, social risk considerations and preventive screenings. You must use the contracted vendor for this service. Contact Customer Care to schedule an appointment.	**There is no coinsurance, copayment, or deductible** for the annual in-home health assessment. **Prior authorization rules may apply. Please contact the plan for details.**
Annual physical exam In addition to the Medicare-covered annual wellness visit listed below, your plan also covers one annual physical exam per calendar year.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered 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	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the annual wellness visit.

Covered Service	What you pay
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.	
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	This type of therapy is called cardiac rehabilitation or intensive cardiac rehabilitation. **In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered therapy visit to treat you if you've had a heart condition. **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams are covered once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services (Medicare-covered) Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each visit that Original Medicare covers to see a chiropractor.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Covered Service	What you pay
tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services (Medicare-covered) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Medicare covers: • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for covered dental services. **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
• Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease • Services that would be covered when provided by a doctor	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes), including fitting. • Diabetes self-management training under certain conditions.	**In Network and Out of Network** **0% coinsurance** for the following diabetic supplies: • A blood glucose meter (excluding continuous glucose monitors – refer to DME section below for coverage of CGMs) • Blood glucose test strips • Lancing devices and glucose lancets • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors. **Please note:** In order to qualify for 0% coinsurance, diabetic test strips and meters must be produced by a preferred manufacturer, **Abbott** or **Trividia**, and be purchased at an in-network retail or mail order pharmacy. Preferred products include some Freestyle, Precision Xtra, True Metrix meters and Trividia test strips. **Not ALL products from preferred manufacturers are considered preferred.** Non-preferred diabetic test strips and meters are covered (with 0% coinsurance) when filled by an in-network durable medical equipment supplier.

Covered Service	What you pay
	0% coinsurance for all other diabetic supplies *See the "Durable medical equipment (DME) and related supplies" section below for cost sharing for insulin pumps and continuous glucose monitors (CGMs).* **Certain supplies considered durable medical equipment may be subject to prior authorization. Please contact the plan for details.** Preferred syringes and pen needles are also covered at zero cost-sharing under your Part D benefit. See plan formulary for preferred products. **In Network and Out of Network** **Covered training to help you learn how to monitor your diabetes:** **There is no coinsurance, copayment, or deductible** for covered training to help you learn how to monitor your diabetes.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at MedMutual.com/MAgroup.	If you receive a durable medical equipment item during an inpatient stay (in a hospital or skilled nursing facility), the cost of the item will be included in your inpatient claim. **You must get durable medical equipment through our participating plan suppliers.** **In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for insulin pumps and continuous glucose monitors (CGMs). **Continuous glucose monitors (CGMs) are only covered with an approved prior authorization.** Your cost sharing for Medicare oxygen equipment coverage is **$0** every month. **There is no coinsurance, copayment, or deductible** for all other durable medical equipment. **Additional prior authorization rules may apply. Please contact the plan for details.** *Go to the "Diabetes self-management training, diabetic services, and supplies" section of this Medical Benefits Chart to see what you pay for diabetic supplies.* *Go to the "Prosthetic and orthotic devices and*

Covered Service	What you pay
	related supplies" section of this Medical Benefits Chart to see what you pay for prosthetics and orthotics.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. This coverage is worldwide. **There is no coinsurance, copayment, or deductible** for each emergency visit to a hospital outside the United States. This applies if you are traveling outside the United States for less than six months. Worldwide emergency/urgently needed services are limited to **$50,000** per calendar year. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay up front for the services rendered. **You must submit receipts to Medical Mutual for reimbursement.** For information about what documentation is required, please see Chapter 3, Section 3.2. For more information about reimbursement, please see Chapter 7, Section 2. We may not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than the rates for providers outside of the U.S. and its territories.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must 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 covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
Health and wellness education programs **Chronic Condition Management Program** This program can help you stay healthy, manage your chronic conditions and maintain	**There is no coinsurance, copayment, or deductible for the Chronic Condition**

Covered Service	What you pay
your independence. A trained health coach, including digital options, works with you to develop a personalized plan that supplements the care you get from your doctor. For more information, call Customer Care at 1-800-801-4823.	**Management Program, Nurse Line or SilverSneakers.**
Nurse Line If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, we can help. Call our Nurse Line toll free at 1-888-912-0636, 24 hours per day, seven days per week for advice. Your call is kept confidential.	
SilverSneakers® Fitness Program SilverSneakers is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members have access to participating gyms and fitness centers. Please note that nonstandard fitness center services that usually have an extra fee are not included in your membership. To take advantage of the program, you'll need your SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY 711 for hearing impaired) Monday through Friday, 8 a.m. to 8 p.m.	
WeightWatchers® Program To help you meet your health goals, we partner with WeightWatchers, the world's leading provider of weight management services. Monthly WeightWatchers membership fees for specified programs are reduced for MedMutual Advantage PPO members. The benefit does not include food or meals. For more information, contact Customer Care at 1-800-801-4823.	**70% coinsurance for the WeightWatchers Program*** *Any cost you pay for this program will not count toward your maximum out-of-pocket amount.
Hearing services (Medicare-covered) Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each Medicare covered hearing exam. If additional medical services, procedures or tests are provided at the time of the visit, additional copayments may apply to those specific services rendered.

Covered Service	What you pay
Additional hearing services Although additional hearing services are not covered by Original Medicare, **your plan covers the following hearing services.** • Audiometric Examinations performed by a Physician-Specialist or Audiologist • Hearing aid evaluation tests performed by a Physician-Specialist or Audiologist • Hearing aids - up to $2,500 toward one hearing aid per ear every rolling 36 months • Hearing aid batteries • Conformity Evaluation • Hearing aid fitting and repair	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered routine hearing exam. For each covered hearing aid, you pay any amount above **$2,500.*** Once the **$125** yearly deductible is met, you pay **20% coinsurance** for hearing aid batteries. **There is no coinsurance, copayment, or deductible** for all other covered hearing services. *Any cost you pay for hearing aids will not count toward your maximum out-of-pocket amount.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for members eligible for Medicare-covered preventive HIV screening.
Home-based palliative care Designed to provide relief and comfort in a home-based setting, this multi-disciplinary specialty medical and nursing program is available for members who have been diagnosed with an advanced illness to help improve their quality of life as they manage their treatment plan. This supportive service is offered through Carelon Health, as well as network provider partners, whose teams can help coordinate care with your own PCP and/or specialist(s). For more information or to find out if you are eligible for this program, call Carelon Health toll free at 1-844-232-0500 (TTY 866-669-7707 for hearing impaired). Covered services include: • **Extra care** – the clinical team is available 24 hours a day, 7 days a week. The team visits patients in their homes and can prescribe medicine when necessary to manage symptoms such as fatigue,	**There is no coinsurance, copayment, or deductible** for covered home-based palliative care services.

Covered Service	What you pay
nausea, shortness of breath, difficulty sleeping, or pain. • **Coordination with current providers** – the clinical team works closely with your existing providers, and can find additional resources that may be beneficial to your family, such as financial, transportation, and meal support. • **Care goals** – the team works with you and your family to identify your healthcare goals, and aligns your care with these goals. **Education** – the team can provide education to you and your family about your illness, plan of care, medications and much more to help you and your family plan for future care needs.	
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for Medicare-covered home health agency care.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for home infusion therapy drugs. **There is no coinsurance, copayment, or deductible** for home infusion equipment and supplies. **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
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	
Home Meals Program After your inpatient stay in a hospital, you are eligible to receive a one-week course of meals, at no extra cost to you. You will receive two meals a day for seven days delivered to your home. The home meal benefit must be requested and authorized within 30 days of discharge from an acute inpatient hospital. For more information about Home Meals or to find out if you are eligible, please contact Customer Care at 1-800-801-4823.	**There is no coinsurance, copayment, or deductible for the Home Meals Program.** **Prior authorization rules may apply. Please contact the plan for details.**
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You'll be billed Original Medicare cost sharing.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not MedMutual Advantage PPO. For the one-time hospice consultation, you pay the office visit cost sharing applicable to your provider type. See the PCP and specialist cost sharing in the "Physician/Practitioner Services" section of this Medical Benefits Chart.

Covered Service	What you pay
For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services. • If you get the covered services from an out-of-network provider, your share of the costs for covered services may be higher **For services covered by MedMutual Advantage PPO but not covered by Medicare Part A or B:** MedMutual Advantage PPO will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. All Advisory Committee on Immunization Practices (ACIP) vaccines are covered under your Part D prescription drug benefit with a $0 copay. Your shingles shot is covered under

Covered Service	What you pay
received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	your Part D benefit. See Chapter 6 Section 8 of this *Evidence of Coverage* for details around administration locations and payment. You may also contact Customer Care at 1-800-801-4823 for more information.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose	For covered hospital stays: Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities and Inpatient Acute Care facilities. **In Network and Out of Network** **Day 1 and thereafter: There is no coinsurance, copayment, or deductible.** **Prior authorization rules may apply. Please contact the plan for details.** For an emergency admission, you or the hospital should tell the plan within one business day of the admission, if possible. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Covered Service	What you pay
to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MedMutual Advantage PPO provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion provided the covered transplant occurs more than 75 miles from your permanent residence. We will cover transportation and lodging for you and a companion up to a maximum of $10,000 per transplant. Meals are not included. Documentation of expenses is required for reimbursement. Please contact Customer Care for details. • Blood - including storage and administration. Coverage of whole blood and packed cells starts with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	A benefit period starts on the first day you go into a hospital. The benefit period ends when you haven't had any inpatient hospital care for 60 days in a row. The plan covers 90 days each benefit period. You have 60 lifetime reserve days that can be used for an inpatient psychiatric admission. You have no copayment for these extra days. **In Network and Out of Network** For covered hospital stays: **Days 1 - 90: There is no coinsurance,**

Covered Service	What you pay
	copayment, or deductible. **Prior authorization rules may apply. Please contact the plan for details.**
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay The plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached this coverage limit, the plan will no longer cover your stay in the SNF. If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	**In Network and Out of Network** You must pay the full cost if you stay in a hospital or skilled nursing facility longer than your plan covers. If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this booklet.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed in the next calendar year.	
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the MDPP benefit.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for chemotherapy/radiation drugs, biologicals and other drugs covered by Medicare Part B – including their administration and all chemotherapy services. Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D initial coverage limit or out-of-pocket limits. Part B drugs will apply to your medical coinsurance and maximum out-of-pocket limits. You still have to pay your portion of the cost allowed by the plan for a Part B drug whether you get it from a doctor's office or a pharmacy. Medicare Part B prescription drugs may be subject to step therapy requirements, meaning that you may be asked to try a different drug first before we will agree to cover the drug you are asking for. *You pay no more than a $35 copayment for a one-month supply of insulin.* **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency	

Covered Service	What you pay
diseases • Parenteral and enteral nutrition (intravenous and tube feeding) Step therapy applies to drugs in the following categories. For additional details please visit the link below. • Cancer and other conditions associated with oncology treatment • Bone disorders • Inflammatory conditions • Joint disorders • Eye disorders • Blood and cell disorders • Other drugs may be added and will be updated with at least 30 days' notice at the link below. This link will take you to a list of Part B drugs that may be subject to Step Therapy: MedMutual.com/MAgroup. We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains the Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D 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.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for covered opioid treatment program services. **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
• Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed cells begins with the first pint of blood that you need • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests	**In Network and Out of Network** Laboratory Services • **There is no coinsurance, copayment, or deductible** for each covered laboratory service. X-ray Services • **There is no coinsurance, copayment, or deductible** for each covered x-ray service, including diagnostic mammogram Ultrasound Services • **There is no coinsurance, copayment, or deductible** for each covered ultrasound Therapeutic Radiology Services (such as radiation therapy for cancer) • **There is no coinsurance, copayment, or deductible** for each covered therapeutic radiology service Original Medicare Covered Diagnostic Tests and Procedures • **There is no coinsurance, copayment, or deductible** for each Original Medicare covered diagnostic test or procedure, such as heart catheterizations and sleep studies Diagnostic Radiological Services • **There is no coinsurance, copayment, or deductible** for each covered Computed Tomography (CT) scan; Magnetic Resonance test (MRI and MRA); or nuclear medicine study, including PET scans Blood, Blood Storage and Processing and Handling Services • **There is no coinsurance, copayment, or deductible** for each covered blood, blood storage, processing and handling service Surgical Supplies • **There is no coinsurance, copayment, or deductible** for each surgical supply, such as dressings Test to Confirm Chronic Obstructive Pulmonary Disease (COPD) • **There is no coinsurance, copayment, or deductible** for each covered test to confirm

Covered Service	What you pay
	COPD **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for observation services
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital	Go to the applicable section of this Medical Benefits Chart to see what you pay for the following services when you get them as Outpatient hospital services: • Emergency Care • Outpatient Diagnostic Tests and Therapeutic Services and Supplies o Laboratory Services o X-ray Services o Ultrasound Services o Therapeutic Radiology Services o Original Medicare Covered Diagnostic Tests and Procedures o Diagnostic Radiological Services (CT scans, MRIs, MRAs, PET scans) o Blood, Blood Storage and Processing and Handling Services o Surgical Supplies

Covered Service	What you pay
• Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	o Test to Confirm Chronic Obstructive Pulmonary Disease (COPD) o Allergy Testing and Treatment • Outpatient mental health care • Outpatient substance use disorder services • Partial hospitalization services and intensive outpatient services • Medicare Part B drugs **In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered surgery or surgical procedure performed as an outpatient at a hospital. **There is no coinsurance, copayment, or deductible** for each covered surgery or surgical procedure performed at an ambulatory surgical center. **There is no coinsurance, copayment, or deductible** for certain covered screenings and preventive services to detect or avoid disease. **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered individual or group 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 and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered physical therapy, occupational therapy, or speech/language therapy visit. **Prior authorization rules may apply. Please contact the plan for details.**
Outpatient substance use disorder services Coverage is available for treatment services that are provided in an ambulatory setting to patients who, for example, have been	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered therapy visit. This

Covered Service	What you pay
discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the intensity of services found only in the inpatient hospital setting. Traditional Outpatient treatment is a level of care in which a licensed mental health professional provides care to individuals in an outpatient setting, whether to the patient individually, in family therapy, or in a group modality either in a professional office or in a hospital outpatient clinic or program.	applies to an individual therapy visit or if the visit is part of group therapy.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered surgery or surgical procedure performed as an outpatient at a hospital. **There is no coinsurance, copayment, or deductible** for each covered surgery or surgical procedure performed at an ambulatory surgical center. You pay a **$0** copayment for each Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility for a preventive colonoscopy. If a polyp is removed during a Medicare-covered screening colonoscopy, the removal will be covered at a $0 copayment. **Prior authorization rules may apply. Please contact the plan for details.**
Partial hospitalization services and Intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT) or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, or licensed marriage and family therapist's (LMFT), or licensed professional	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered partial hospitalization visit or intensive outpatient service visit. **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
counselor's office but less intense than partial hospitalization.	
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care physician services and physician specialist services o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Telehealth services must have an audio, video, or other electronic component, and the provider must determine that care can be provided in this format. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered PCP visit. **There is no coinsurance, copayment, or deductible** for each covered specialist visit (including office visits to psychologists and psychiatrists; and non-routine dental care). **Prior authorization rules may apply. Please contact the plan for details.**

Covered Service	What you pay
provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	
Podiatry services (Medicare-covered) Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each Original Medicare covered podiatry visit. **Prior authorization rules may apply. Please contact the plan for details.**
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include:	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the PrEP benefit.

Covered Service	What you pay
• FDA -approved oral or injectable PrEP medication, including the fee for injecting the drug, if applicable. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	
Prostate cancer screening exams For men, age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for an annual PSA test.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	You must get prosthetic and orthotic devices and the supplies that go with them from a supplier who works with this plan. You cannot purchase these items from a pharmacy. If you buy them from a pharmacy they will not be covered. **In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for prosthetic and orthotic devices and supplies. **Prior authorization rules may apply. Please contact the plan for details.**
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Hyperbaric and respiratory rehabilitation services are included in this benefit.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered visit. **Prior authorization rules may apply. Please contact the plan for details.**
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered Service	What you pay
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.	
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered screening for the Hepatitis C Virus.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are:** people age 50 - 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered screening

Covered Service	What you pay
STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered visit to learn about kidney care and how to care for yourself if you need kidney dialysis. **There is no coinsurance, copayment, or deductible** for covered dialysis equipment or supplies. **There is no coinsurance, copayment, or deductible** for kidney dialysis when you use a network provider or you are temporarily out of the service area. You pay only the inpatient hospital copayment for dialysis when received as an inpatient. You do not need to get an approval from the plan before getting dialysis. But, please let us know when you need to start this care, by calling our Care Management department toll free at 1-855-887-2273, so we can help coordinate with your doctors. **Prior authorization rules may apply. Please contact the plan for details.**
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care,	**In Network and Out of Network** For covered SNF stays:

Covered Service	What you pay
go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We will pay for skilled nursing facility care for up to 100 days per benefit period. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed cells begins with the first pint of blood you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	**There is no coinsurance, copayment, or deductible for covered skilled nursing facility care.** A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended a new benefit period begins. There is no limit on how many benefit periods of coverage you can have. **Prior authorization rules may apply. Please contact the plan for details.**
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	
Your plan also offers six additional coaching sessions, as well as a supply of nicotine replacement therapy, in the form of patches or gum, at no cost. For more information, call Customer Care at 1-800-801-4823.	**There is no coinsurance, copayment, or deductible** for additional smoking and tobacco use cessation support.
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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered SET visit **Prior authorization rules may apply. Please contact the plan for details.**
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered urgent care center visit. For urgently needed services received at a PCP's or specialist office, please see the office

Covered Service	What you pay
unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits(like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgent care services are worldwide. **You pay a $0 copayment** for each urgent care center visit outside the United States. This applies if you are traveling outside the United States for less than six months. Worldwide emergency/urgently needed services are limited to **$50,000** per calendar year. You will be responsible to pay up front for worldwide urgent care services. **You must submit receipts to Medical Mutual for reimbursement.** For information about what documentation is required, please see Chapter 3, Section 3.2. For more information about reimbursement, please see Chapter 7, Section 2. We may not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than the rates for providers outside of the U.S. and its territories.	visit copayments listed under "Physician/Practitioner services."
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for Original Medicare covered eye exams and screenings. Eye refractions have the same cost-sharing as Original Medicare covered eye exams – see additional non-Medicare vision services covered by your plan below. **There is no coinsurance, copayment, or deductible** for Original Medicare covered eyeglasses or contact lenses after cataract surgery.

Covered Service	What you pay
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.)	
In addition to the vision services covered by Original Medicare listed above, your plan also covers: • Eye refractions associated with a Medicare-covered eye exam	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for each covered eye refraction.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	**In Network and Out of Network** **There is no coinsurance, copayment, or deductible** for the *Welcome to Medicare* preventive visit.

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances. Refer to the "Acupuncture for chronic low back pain" benefit in the Medical Benefits Chart in Section 2 for details.
Any non-emergency or non-urgent care received outside of the United States and the U.S. Territories	**Not covered under any condition**

Services not covered by Medicare	Covered only under specific conditions
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	**Not covered under any condition**
Diagnostic services performed in a chiropractor's office	**Not covered under any condition**
Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy	**Not covered under any condition**
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, support stockings and other primarily non-medical equipment	**Not covered under any condition**
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	**Not covered under any condition**
Full-time nursing care in your home	**Not covered under any condition**
Gender affirming surgery	**Not covered under any condition**
Home-delivered meals	After your inpatient stay in a hospital, you are eligible to receive a one-week course of meals, at no extra cost to you. You will receive two meals a day for seven days delivered to your home.
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household help, including light housekeeping or light meal preparation	**Not covered under any condition**
Immunizations for foreign travel purposes	**Not covered under any condition**
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition** Although naturopath services are not covered, acupuncture is covered under specific conditions. See above.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Non-therapeutic abortions	**Not covered under any condition**
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to, home and car remodeling or modification, and exercise equipment	**Not covered under any condition**
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Over-the-counter purchases, unless such services are specifically listed in the benefits section of this agreement	**Not covered under any condition**
Patient convenience transfers between skilled nursing facilities and hospitals, including any transportation, facility or physician charges associated with such	**Not covered under any condition**
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	**Not covered under any condition**
Private room in a hospital	Covered only when medically necessary
Procedures, services, supplies and medications until they are reviewed for safety, efficacy and cost-effectiveness, and approved by Medicare and Medical Mutual	**Not covered under any condition**

Services not covered by Medicare	Covered only under specific conditions
Reversal of sterilization procedures and or non-prescription contraceptive supplies	**Not covered under any condition**
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings or dentures	**Not covered under any condition**
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition**
Services that are not covered under Original Medicare, unless such services are specifically listed in the benefits section of this agreement	**Not covered under any condition**
Services you get without prior authorization when prior authorization is required for such services	**Not covered under any condition**
Transports by wheelchair van or ambulette and trips to or from a physician's office	**Not covered under any condition**
Treatment for injuries received while engaged in an illegal activity	**Not covered under any condition**

Services we do not cover (exclusions) under the mandatory supplemental additional hearing benefits:

- Hearing examinations or materials ordered as a result of a hearing examination prior to your effective date.
- Replacement of hearing aids that are lost or broken, unless at the time of such replacement, 36 months have elapsed since you last received a hearing aid for which coverage was provided.
- Ear molds and ear impressions.
- Which are not prescribed by or performed by or upon the direction of a Hearing Coverage Provider.

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription that's 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 (go to Section 2). Or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory,* visit our website (MedMutual.com/MAgroup), and/or call Customer Care at 1-800-801-4823 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The Pharmacy Directory will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, call Customer Care at 1-800-801-4823 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at MedMutual.com/MAgroup.

Specialized pharmacies

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, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Care at 1-800-801-4823 (TTY users call 711).
- 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* (MedMutual.com/MAgroup) or call Customer Care at 1-800-801-4823 (TTY users call 711).

Section 2.2 Our plan’s mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **mail-order drugs** in our Drug List.

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

Our plan's preferred mail order service may have a lower cost-share compared to a standard mail order pharmacy. However, to take advantage of the lower cost-sharing, you must fill your prescription for at least a two-month supply. Please contact Part D Customer Service at 1-844-404-7947 for information.

To get order forms and information about filling your prescriptions by mail, please call Customer Care at 1-800-801-4823.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail order may be delayed. Please call Part D Customer Service toll free at 1-844-404-7947 if you have not received your prescription within two weeks of ordering.

New prescriptions the pharmacy gets directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it gets 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 can ask for automatic delivery of all new prescriptions at any time by providing consent on your first new home delivery prescription sent in by your doctor or health provider.

If you get a prescription automatically by mail that you don’t 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 don’t want the pharmacy to automatically fill and ship each new prescription, contact us by calling Part D Customer Service at 1-844-404-7947.

If you 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’s important to respond each time you’re contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care

provider's office, contact us by calling Part D Customer Service toll free at 1-844-404-7947.

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

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail order refills, contact us by calling Customer Care at 1-800-801-4823.

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

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 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 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 (which offer preferred cost sharing) at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Pharmacy Directory* (MedMutual.com/MAgroup) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care at 1-800-801-4823 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. **Check first with Customer Care at 1-800-801-4823 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If the prescriptions are related to care for a medical emergency or urgently needed care, they will be covered. In this situation, you will have to pay the full cost (rather than paying just the copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you by submitting a paper claim to us for up to usual, customary, and reasonable (UCR). Any amount you pay over the UCR will be applied to your Part D Out-Of-Pocket Costs.

- If you are traveling within the United States, but outside the plan's service area, and you become ill or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy (if you follow all other coverage rules identified within this document and a network pharmacy is unavailable). In this situation, you will have to pay the full cost (rather than paying just the copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you by submitting a paper claim to us for up to usual, customary, and reasonable (UCR). Any amount you pay over the UCR will be applied to your Part D Out-of-Pocket Costs.
- If you are unable to get a covered drug in a timely manner within our service area, because there is not a network pharmacy within a reasonable driving distance which provides 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail-order pharmacy (these drugs include orphan drugs or specialty pharmaceuticals).
- Self-administered medications that you receive in an outpatient setting may be covered under Part D. For consideration, please submit a paper claim.

If you must use an out-of-network pharmacy, you'll 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. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs (formulary).* In this *Evidence of Coverage,* **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. 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. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 6 cost-sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Cost-sharing Tier 1:** includes preferred generic drugs.
- **Cost-sharing Tier 2:** includes generic drugs.
- **Cost-sharing Tier 3:** includes preferred brand drugs and generic drugs.
- **Cost-sharing Tier 4:** includes non-preferred drugs. This tier includes generic and brand drugs.
- **Cost-sharing Tier 5:** the highest cost-sharing tier, includes specialty drugs. These high cost drugs generally require special storage or handling and close monitoring of the patient's drug therapy. They are usually used to treat chronic conditions. This tier is limited to a 30-day supply.
- **Cost-sharing Tier 6:** the lowest cost-sharing tier. This tier includes low-cost generic maintenance drugs (select care drugs). It is important to take these medications as your doctor prescribed.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find our if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit the plan's website (MedMutual.com/MAgroup). The Drug List on the website is the most current.
- Call Customer Care at 1-800-801-4823 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or to ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (Log in to MedMutual.com/Member and select "Prescription Drug Benefits" under the Quick Links) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Care at 1-800-801-4823 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our 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, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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 example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider has to take extra steps for us to cover the drug. Call Customer Care at 1-800-801-4823 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider needs to get approval from our plan based on specific criteria before we 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 don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Care at 1-800-801-4823 (TTY users call 711) or on our website (MedMutual.com/MAgroup).

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Customer Care at 1-800-801-4823 (TTY users call 711) or on our website (MedMutual.com/MAgroup).

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's 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 you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year,** we'll 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 a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:**
  We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those members who have been in the plan for more than 90 days and experience a level of care change (from one treatment setting to another):**
  We will provide up to a one-month supply of a Non-Formulary Drug and/or a drug that may be restricted in some way, or less if your prescription is written for fewer days.
- Other times when we will cover a temporary one-month transition supply (or less, if you have a prescription written for fewer days) include:
  - When you enter a long-term care facility
  - When you leave a long-term care facility
  - When you are discharged from a hospital
  - When you leave a skilled nursing facility
  - When you cancel hospice care

  The plan will send you a letter within three business days of your filling a temporary transition supply, notifying you that this was a temporary supply and explaining your options.

For questions about a temporary supply, call Customer Care at 1-800-801-4823 (TTY users call 711).

During the time when you're 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 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Care at 1-800-801-4823 (TTY users call 711) 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.

Option 2. You can ask for an exception

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

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

Section 5.1 What to 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 Customer Care at 1-800-801-4823 (TTY users call 711) 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 our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.2 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our 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.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

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 regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing 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 take that drug, we'll tell you after we make the change.
- **Making 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 based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - We'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're 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 won't 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 take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll 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 drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

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

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't 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 requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. This includes cough and cold; vitamins and minerals; erectile dysfunction; antihistamines; diabetic supplies without syringe; anti-obesity; and serotonin 5 HT-receptor agonists (Addyi) drugs – see the Prescription Drug Certificate at the end of this booklet for more information. The amount you pay for these drugs doesn't count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

If you get **Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at 1-800-801-4823 (TTY users call 711) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

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

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

Section 9.2 As 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 its residents. If you're 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's part of our network.

Check your *Pharmacy Directory* (MedMutual.com/MAgroup) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Care at 1-800-801-4823 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in

some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse's) employer or retiree group, contact **that group's benefits administrator.** They can help you understand how your current 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 pays first.

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

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

Keep any notices about creditable coverage, because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication, or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting 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

We conduct drug use reviews to help make sure our members get 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 like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar 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're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use 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 prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, 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 prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers 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'll 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'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage 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 our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use 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 get 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. 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'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Customer Care at 1-800-801-4823 (TTY users call 711).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does 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, call Customer Care at 1-800-801-4823 (TTY users call 711), and ask for the *LIS Rider*.

We use "drug*"* in this chapter to mean a Part D prescription drug. 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 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (MedMutual.com/MAgroup), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Customer Care at 1-800-801-4823 (TTY users call 711).

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

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our 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 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't 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 covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:
When you (or those paying on your behalf) have spent a total of **$1,000** in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- The amount you or your former employer or your retiree group pays for your monthly premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Care at 1-800-801-4823 (TTY users call 711).

Tracking of your out-of-pocket total costs

- The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $1,000, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for MedMutual Advantage PPO members

There are **3 drug payment stages** for your drug coverage under MedMutual Advantage PPO How much you pay for each prescription. depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

SECTION 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** This is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

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

Section 3.1 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's 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 make sure we know about the prescriptions you fill and what you pay.
- **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 won't 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. **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 use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're 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 make for you.** Payments made by certain other people 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 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 get 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 questions, call Customer Care at 1-800-801-4823 (TTY users call 711). Be sure to keep these reports.

SECTION 4 There is no deductible for MedMutual Advantage PPO

There is no deductible for MedMutual Advantage PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

Section 4.1 What is the most you will pay for prescription drugs?

In addition to the in-network and combined maximum out-of-pocket amounts for covered Part A and Part B services (see Chapter 4, Section 1.2), we also have a separate **$1,000** Pharmacy maximum out-of-pocket amount that applies only to drugs covered by your plan. This is the most you pay during the calendar year for prescription drugs from network pharmacies. Once you have paid $1,000 out-of-pocket for copays or coinsurance for your prescription drugs, the plan will cover your prescription drugs at no cost to you for the rest of the calendar year.

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered 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.

Our plan has 6 cost-sharing tiers

Every drug on our plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Cost-sharing Tier 1:** includes preferred generic drugs.
- **Cost-sharing Tier 2:** includes generic drugs.
- **Cost-sharing Tier 3:** includes preferred brand drugs and generic drugs. *You pay $35 per month supply of each covered insulin product on this tier.*
- **Cost-sharing Tier 4:** includes non-preferred drugs. This tier includes generic and brand drugs. *You pay $35 per month supply of each covered insulin product on this tier.*
- **Cost-sharing Tier 5:** the highest cost-sharing tier, includes specialty drugs. These high cost drugs generally require special storage or handling and close monitoring of the patient's drug therapy. They are usually used to treat chronic conditions. This tier is limited to a 30-day supply.
- **Cost-sharing Tier 6:** the lowest cost-sharing tier. This tier includes low-cost generic maintenance drugs (select care drugs). It is important to take these medications as your doctor prescribed.

To find out which cost-sharing tier your drug is in, look it up in our 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 that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers standard cost sharing.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* (MedMutual.com/MAgroup).

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

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 costs for a *one-month* supply of a covered Part D drug:

Tier	**Standard retail in-network cost sharing** (up to a 30-day supply)	**Preferred retail in-network cost sharing** (up to a 30-day supply)	**Standard mail-order cost sharing** (up to a 30-day supply)	**Preferred 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; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-sharing Tier 1 (Preferred Generic drugs)	**$10 copayment**	**$0 copayment**	**$10 copayment**	**$0 copayment**	**$10 copayment**	**$10 copayment** plus the cost difference between the network and out-of-network pharmacy
Cost-sharing Tier 2 (Generic drugs)	**$10 copayment**	**$5 copayment**	**$10 copayment**	**$5 copayment**	**$10 copayment**	**$10 copayment** plus the cost difference between the network and out-of-network pharmacy

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Preferred retail in-network cost sharing (up to a 30-day supply)	Standard mail-order cost sharing (up to a 30-day supply)	Preferred 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; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-sharing Tier 3 (Preferred Brand and Generic drugs)	**20% coinsurance ($25 min./$75 max.)**	**15% coinsurance ($20 min./$70 max.)**	**20% coinsurance ($25 min./$75 max.)**	**15% coinsurance ($20 min./$70 max.)**	**20% coinsurance ($25 min./$75 max.)**	**20% coinsurance** plus the cost difference between the network and out-of-network pharmacy
Cost-sharing Tier 4 (Non-Preferred drugs)	**40% coinsurance ($40 min./$150 max.)**	**35% coinsurance ($35 min./$145 max.)**	**40% coinsurance ($40 min./$150 max.)**	**35% coinsurance ($35 min./$145 max.)**	**40% coinsurance ($40 min./$150 max.)**	**40% coinsurance** plus the cost difference between the network and out-of-network pharmacy
Cost-sharing Tier 5 (Specialty drugs)	**40% coinsurance ($40 min./$150 max.)**	**35% coinsurance ($35 min./$145 max.)**	**40% coinsurance ($40 min./$150 max.)**	**35% coinsurance ($35 min./$145 max.)**	**40% coinsurance ($40 min./$150 max.)**	**40% coinsurance** plus the cost difference between the network and out-of-network pharmacy
Cost-sharing Tier 6 (Select Care drugs)	**$10 copayment**	**$0 copayment**	**$10 copayment**	**$0 copayment**	**$10 copayment**	**$10 copayment** plus the cost difference between the network and out-of-network pharmacy

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Go to Section 7 of this chapter for more information on 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 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're 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 if this will help you plan refill dates better.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're 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're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

Section 5.4 Your costs for a *long-term* up to a 90-day supply of a covered Part D 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.

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 costs for a *long-term* (up to a 90-day) supply of a covered Part D drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard mail-order cost sharing** (up to a 90-day supply)	**Preferred mail-order cost sharing** (up to a 90-day supply)
Cost-sharing Tier 1 (Preferred Generic drugs)	**$25 copayment**	**$0 copayment**	**$25 copayment**	**$0 copayment**
Cost-sharing Tier 2 (Generic drugs)	**$25 copayment**	**$10 copayment**	**$25 copayment**	**$10 copayment**
Cost-sharing Tier 3 (Preferred Brand and Generic drugs)	**20% coinsurance ($65 min./$155 max.)**	**15% coinsurance ($60 min./$150 max.)**	**20% coinsurance ($65 min./$155 max.)**	**15% coinsurance ($60 min./$150 max.)**
Cost-sharing Tier 4 (Non-Preferred drugs)	**40% coinsurance ($95 min./$305 max.)**	**35% coinsurance ($90 min./$300 max.)**	**40% coinsurance ($95 min./$305 max.)**	**35% coinsurance ($90 min./$300 max.)**

Tier	**Standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** (up to a 90-day supply)	**Standard mail-order cost sharing** (up to a 90-day supply)	**Preferred mail-order cost sharing** (up to a 90-day supply)
Cost-sharing Tier 5 (Specialty drugs)	**40% coinsurance ($95 min./$305 max.)**	**35% coinsurance ($90 min./$300 max.)**	**40% coinsurance ($95 min./$305 max.)**	**35% coinsurance ($90 min./$300 max.)**
Cost-sharing Tier 6 (Select Care drugs)	**$25 copayment**	**$0 copayment**	**$25 copayment**	**$0 copayment**

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $1,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $1,000. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the $1,000 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage does not apply to you

Section 6.1 Because your plan has a $1,000 Pharmacy maximum out-of-pocket, you are not expected to meet the $2,400 out-of-pocket amount to reach the Catastrophic Coverage Stage

During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to our plan's Drug List or call Customer Care at 1-800-801-4823 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines 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. Or a provider may give it in the doctor's office.

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

- When you get a vaccine, you may have to pay 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'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

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

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you 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 vaccine at your doctor's office.

- When you get the vaccine, you may have to pay 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 described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll 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'll reimburse you for this difference.)

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you 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'll be reimbursed the full amount you paid. For other Part D vaccines, you'll 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'll reimburse you for this difference.)

CHAPTER 7:
Asking us to pay our share of a bill 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 pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

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

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

When you got care from a provider who isn't part of our network, you're 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 our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
  - If the provider is owed anything, we'll pay the provider directly.
  - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- 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 can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

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

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

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

3. If you’re retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any 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 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 fill a prescription

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 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. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we’d pay at an in-network pharmacy.

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

If you don’t have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can’t 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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 the drug isn’t covered for some reason.

- For example, the drug may not be on our plan’s Drug List or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or Part B drug. **You must submit your Part D (drug) claim to us within 36 months** of the date you got the service, item, or drug.

To make sure you're 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'll help us process the information faster. Be sure to include your name, date of service, total charge, description of services rendered along with any corresponding codes (diagnosis and procedure codes), as well as provider of service name and location where services were rendered.
- Download a copy of the form from our website (MedMutual.com/Member) or call Customer Care at 1-800-801-4823 (TTY users call 711) and ask for the form.

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

For Part C (medical) claims:

Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018

For Part D (prescription drug) claims:

Express Scripts
ATTN: Medicare Part D
P.O. Box 52023
Phoenix, AZ 85072

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

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

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Care at 1-800-801-4823 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Care at 1-800-801-4823. You can 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 you get timely access to covered services and drugs

You have the right to choose a provider for your care.

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 you aren't 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're 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 don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D 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's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Care at 1-800-801-4823 (TTY users call 711).

NOTICE OF PRIVACY PRACTICES

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

Your Privacy Is Important to Us

Medical Mutual has always been committed to protecting the information you share with us. Medical Mutual is required by law to maintain the privacy of your personal information as well as your protected health information, as defined by the privacy and security rules under the Health Insurance Portability and Accountability Act ("HIPAA"), and to provide you with this Notice of Privacy Practices (this "Notice") describing our legal duties and privacy practices with respect to your information. This Notice applies to Medical Mutual of Ohio and its Family of Companies, which includes Medical Health Insuring Corporation of Ohio, Superior Dental Care, Inc., Reserve National Insurance Company (MedMutual Protect), Paramount Insurance Company, Paramount Care, Inc., Paramount Care of Michigan, Inc., and Paramount Care of Indiana, Inc. This Notice also applies to our wholly owned subsidiaries Medical Mutual Services, LLC and Mutual Health Services, a division of Medical Mutual Services, LLC, as applicable, in their capacity as business

associates to group health plans (herein referred to collectively as "Medical Mutual," "we," "our" or "us").

What Information We Collect

Medical Mutual understands your concerns about the confidentiality of information you share with us. We collect information from you on applications and other transactions with us. This information can include your name, address and Social Security number. Under certain conditions we may ask you and your covered dependents for medical history information. We also have access to your information through:

- Claims or lab results submitted to us from healthcare providers
- Information provided by your plan sponsor if your coverage is through an employer sponsored group health plan or a group retiree health plan, and Information provided by your agent if you purchased your coverage through an agent.

How We Use and Disclose Your Protected Health Information ("PHI")

We are permitted by law to use your PHI for certain purposes including treatment, payment and healthcare operations. Examples of how we may use and disclose your information include but are not limited to:

Treatment: Medical Mutual may use or disclose your PHI to aid in your treatment or the coordination of your care. For example, although we do not provide treatment, we may share your information with a healthcare provider to help the provider treat you.

Payment: Medical Mutual may use or disclose your PHI to determine your coverage and to pay claims for healthcare you receive. For example, we may provide eligibility information to your doctor when you receive treatment. We may also use or disclose your information to obtain payment of premiums or to coordinate benefits and payment with other entities that may have an obligation to pay for your healthcare.

Healthcare Operations: Medical Mutual may use or disclose your PHI for activities that are necessary to operate our business and ensure you receive quality services, like:

- Underwriting, premium rating or other activities relating to the creation or renewal of a health insurance contract. If Medical Mutual uses or discloses your information for underwriting purposes, we are prohibited by law from, and will not, use or disclose your genetic information for such purposes.
- Quality assessment and improvement activities such as peer review and credentialing of providers and other activities to improve the quality of the services we provide to you
- Care coordination and case and disease management activities, and
- Data and information systems management. For example, we may discuss with your doctor a disease management or wellness program appropriate for your condition.

As Required by Law: Medical Mutual must allow the U.S. Department of Health and Human Services access to audit our records. In addition, Medical Mutual may release or disclose your PHI if we are required to do so to comply with other laws or for certain public policy purposes, including:

- To comply with legal proceedings, such as court orders, administrative orders or subpoenas
- To perform mandatory licensing and regulatory/compliance reporting
- To law enforcement officials for limited law enforcement purposes
- To federal officials for lawful intelligence, counterintelligence and other national security purposes
- To public health authorities for public health purposes
- To report child or domestic abuse
- To a coroner, medical examiner, or funeral director related to a deceased individual

- For organ, eye, or tissue donation purposes
- For certain legally approved research activities
- To avert a serious threat to an individual's or the public's health or safety
- To health oversight agencies for health oversight activities authorized by law, including audits, investigations, or licensure activities, and
- To comply with workers' compensation and other similar programs established by law that provide for benefits for work-related injuries or illness without regard to fault.

To Business Associates: Medical Mutual may disclose your PHI to third parties we hire to assist in the administration of your benefits. These third parties are called Business Associates, and they must agree in writing to protect and maintain the confidentiality and security of your PHI. Examples of a Business Associate are doctors who perform medical reviews of your claims or appeals and brokers who service your policy.

To Plan Sponsors: If you receive insurance benefits through a group plan, Medical Mutual may disclose to the plan sponsor, in summary form, claims history and other similar information about the group plan.

Such summary information does not disclose your name or other personally identifiable information. We may also disclose to the plan sponsor the fact you are enrolled in, or disenrolled from the group plan. We may disclose your PHI to the plan sponsor for administrative functions the plan sponsor provides to the group plan if the plan sponsor agrees in writing to ensure the continuing confidentiality and security of your information. The plan sponsor must also agree not to use or disclose your PHI for employment-related activities or for any other benefit or benefit plans of the plan sponsor.

To Organized Health Care Arrangements: Medical Mutual participates with certain healthcare providers in accountable care organizations that are organized health care arrangements to improve coordination and quality of care, reduce hospitalization, and better control healthcare costs. We may use and disclose your PHI to other participants in the accountable care organizations for the health care operations activities of the organization, such as to ensure care coordination, improve quality of care and control healthcare costs.

Other Uses and Disclosures: Medical Mutual may also disclose your PHI:

- To a personal representative appointed by you or designated by law
- To appropriate military authorities, if you are a member of the armed forces
- To a family member, friend or other person for the purpose of helping you with your healthcare or healthcare payment if you are in an emergency situation and you cannot give your agreement to Medical Mutual to do this or if you have had an opportunity to object and have not done so
- To notify a family member or other individual involved in your care of your location, general condition, or death, or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications, or
- To provide you with appointment reminders and to inform you of treatment alternatives or other health related benefits or services that may be of interest to you.

Uses and Disclosures with Your Permission: Medical Mutual will not use or disclose your PHI for purposes not outlined in this Notice unless you give Medical Mutual your written authorization to do so. Your authorization will be required for most of Medical Mutual's uses and disclosures of psychotherapy notes about you, uses and disclosures of your PHI for marketing purposes, and disclosures that constitute a sale of your PHI, where required by HIPAA. If you give Medical Mutual your written authorization, you may revoke that authorization at any time. However, your revocation will have no effect on any action Medical Mutual previously took in reliance on your authorization. To receive an authorization form, please contact Customer Care at the number on your member identification (ID) card or print one from our website, **MedMutual.com, under**

the HIPAA section. If a family member calls with knowledge of your claim, we may confirm certain information about it, unless you have informed us in writing of a need for confidential communication (as described below).

Substance Use Disorder Treatment Information: If Medical Mutual receives or maintains any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program"), through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment, or health care operations, we may use or disclose your Part 2 Program record for treatment, payment, and/or health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to Medical Mutual or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. You may revoke your consent at any time in writing, except to the extent that we already acted in reliance on your consent.

In no event will Medical Mutual use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or a court order that is accompanied by a subpoena or other legal requirement compelling disclosure after providing you notice of the court order and an opportunity to be heard.

Other Privacy Laws: Under HIPAA, Medical Mutual may be required to comply with other more stringent state or federal privacy laws that require greater limits on disclosure of your PHI, such as 42 CFR Part 2 related to substance use disorder treatment records.

Your Rights

You have certain privacy and confidentiality rights as a member of Medical Mutual.

Restriction: You may request Medical Mutual place additional restrictions on the use and disclosure of your PHI to carry out treatment, payment or healthcare operations. Medical Mutual generally does not have to agree to your request unless you have paid out of pocket in full for services.

Confidential Communications: You may request Medical Mutual communicate with you in confidence about your PHI at a different location or by a different means. Medical Mutual does not have to honor this request unless (1) you state that such a change in communication is necessary to avoid endangering you; (2) your request allows Medical Mutual to continue to collect premiums and pay claims; and (3) your request is reasonable.

Access to Your Information: You have a right to inspect and copy your PHI used and stored by Medical Mutual in its designated record set, including an electronic copy. Medical Mutual may charge a reasonable, cost-based fee for copies. For access to your entire medical record held by your health care provider, you must contact the provider of service.

Amend Your Information: You have the right to request an amendment of your PHI. Medical Mutual cannot amend information it did not create and will refer you to the provider of service if you are requesting an amendment to diagnosis or treatment information. Medical Mutual also may deny your request for an amendment if it believes your information is accurate and complete.

Disclosures: You have a right to an accounting of certain disclosures of your PHI made by Medical Mutual and its Business Associates over the last six years, except for disclosures you have authorized or for treatment, payment, and health care operations purposes.

Exercising these rights: Please note all requests described above must be made in writing. We have provided forms to help in processing your request. The appropriate forms are available under the HIPAA section on our website, MedMutual.com. You also may call Customer Care at the number on your member ID card to obtain copies of the appropriate forms. Hearing-impaired customers may contact us at 711 or (800) 750-0750. All completed forms and requests are to

be mailed to:

Medical Mutual of Ohio
P.O. Box 89499
Cleveland, OH 44101-6499

Fundraising: If Medical Mutual sends you a fundraising communication, you have a right to opt out of receiving future fundraising communications. Each communication will describe the opt-out mechanism. If Medical Mutual intends to use or disclose Part 2 Program records for fundraising purposes, you will be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications.

Breach Notification: You have the right to, and will receive, notification from us following a breach of your unsecured PHI. Such notice will describe what happened; the information that was breached, any steps you should take to protect yourself from potential harm, Medical Mutual's investigation and mitigation efforts and contact information for questions.

Complaints: You have the right to complain if you believe your rights have been violated. You may use the form under the HIPAA section on our website, MedMutual.com, to submit your complaint. You may file a complaint by contacting Customer Care at the number on your member ID card, if you wish not to send it in writing. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. Federal law prohibits retaliation against you if you choose to file a complaint.

Contact Information: If you have questions or would like an additional copy of this Notice, please call the Customer Care number on your member ID card. Even if you have agreed to receive this Notice by electronic means, you still have the right to receive a paper copy.

Security Procedures

Medical Mutual takes the security of your information very seriously and has established security standards and procedures to prevent unauthorized access to your electronic PHI. We maintain physical, technical and administrative safeguards to protect your PHI in any form, including oral, written and electronic across the organization. All authorized personnel within our organization who deal with your PHI are bound to confidentiality through a confidentiality agreement and are trained on a regular basis on corporate policies and procedures with respect to privacy and security.

Effective Date

The effective date of this notice is February 16, 2026. Medical Mutual is required to follow the terms of this notice until it is replaced. Medical Mutual reserves the right to change this Notice at any time as allowed by law and will notify you of any changes as required by law. Medical Mutual reserves the right to make such changes apply to all information it maintains.

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

As a member of MedMutual Advantage 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 Customer Care at 1-800-801-4823 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our 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 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 isn't 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 You have the right to know your treatment options and participate in decisions about your care

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. 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. 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's to be done if you can't make medical decisions for yourself

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the following agencies.

For complaints regarding physicians, contact the Medical Board in the state in which your physician is located. If you need that phone number, Customer Care can assist you.

For complaints regarding hospital/health care facilities, contact the Department of Health in the state in which the hospital/health care facility is located. If you need that phone number, Customer Care can assist you.

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

If you have any problems, concerns, or complaints and need to ask for coverage or make an appeal, Chapter 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're required to treat you fairly.**

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

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

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

- **Call Customer Care at 1-800-801-4823 (TTY users call 711)**
- **Call your local SHIP** at 1-800-686-1578 (TTY users call 711)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Care at 1-800-801-4823 (TTY users call 711)**
- **Call your local SHIP** at 1-800-686-1578 (TTY users call 711)
- **Contact Medicare.**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Care at 1-800-801-4823 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
    - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D 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 you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - If you're responsible for a premium, you must pay it.
    - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
    - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
    - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
    - If you're 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 stay a member of our 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* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9
If you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Care at 1-800-801-4823 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in Appendix 1 of this document.

Medicare

You can also contact Medicare for help:

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

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

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

Making an appeal

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

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

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Customer Care at 1-800-801-4823 (TTY users call 711).**
- **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 need to be appointed as your representative. Call Customer Care at 1-800-801-4823 (TTY users call 711)and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at MedMutual.com/MAgroup.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Customer Care at 1-800-801-4823 (TTY users call 711)and ask for the Appointment of Representative form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at MedMutual.com/MAgroup.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8**: 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 information applies to you, call Customer Care at 1-800-801-4823 (TTY users call 711). You can also get help or information from your SHIP.

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

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

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

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled

nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

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

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

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you

an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B prescription drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to 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 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

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

Step 2: Ask our plan for an appeal or a fast appeal.

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.

- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term

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

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

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your case file. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

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

- For the fast appeal the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 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. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to 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 don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't 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'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **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 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 Asking for an exception

Legal Terms:

Asking for coverage of a drug that is not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd 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 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug List.
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 6 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you 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 can't 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's more than one lower cost-sharing tier with alternative drugs you can't take, you 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 you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically 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're requesting and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally *won't* 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 our 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 How to ask for a coverage decision, including an exception

Legal Term:

A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't 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'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll 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 asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask 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*, which is available on our website (MedMutual.com/MAgroup). Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows 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 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason 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 get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll 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 get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.**

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

- If you're appealing a decision we made about a drug you didn't get yet, 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.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at** 1-800-801-4823. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (MedMutual.com/MAgroup). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for 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're allowed to charge a fee for copying and sending this information to you.

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

- When we review your appeal, we take another careful look at all 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 get your appeal**. We'll give you our answer sooner if your health requires us to.

- If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you 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 didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.6 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 independent review organization.

- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all the information about 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 gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent 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 independent review organization **within 72 hours** after we get the decision from the independent 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're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent 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's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 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're being discharged too soon

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

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

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

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Care at 1-800-801-4823 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your**

rights.

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

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.

To look at a copy of this notice in advance, call Customer Care at 1-800-801-4823 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 1-800-801-4823 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), Ohio Senor Health Insurance Information Program, for personalized help at 1-800-686-1578 (TTY users call 711). SHIP contact information is available in Chapter 2, Section 3.

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

- **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it 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 independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

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

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

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

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

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

If the independent 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 want to continue with the review process.

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

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

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

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

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

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

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

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 1-800-801-4823 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), Ohio Senior Health Insurance Information Program, at 1-800-686-1578 (TTY users call 711) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

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

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

How can you contact this organization?

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

Act quickly:

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

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

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

Legal Term:

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

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

Level 4 appeal

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

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

Level 5 appeal

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

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

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal 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 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 customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

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

- **Calling Customer Care at 1-800-801-4823 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Care will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **Grievance process.** You or your representative may file your concerns in writing or verbally. Please follow the grievance process described below.

  When filing a grievance, please provide the following information:
  - Your name, address, telephone number where we can reach you if we have questions; your ID Number from your plan membership card; for written grievances, your or your authorized representative's signature and the date signed; a summary of the grievance and your description of any previous contact with us on the matter; and a description of the action you are requesting to resolve the grievance. If you or your authorized representative require assistance in preparing and submitting your written grievance, contact Customer Care at the number shown in Chapter 2 of this booklet.

  You may request an expedited (fast) grievance if:
  - You disagree with our decision to extend the timeframe to make an initial (standard) organization/coverage determination or reconsideration
  - We deny your request for a 72-hour/fast (expedited) organization/coverage determination or reconsiderations/redeterminations
  - We deny your request for a 72-hour/fast (expedited) appeal

  If you mail the request for an expedited grievance, we will provide oral acknowledgement upon receipt. We will make a determination within 24 hours of receipt of your request.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**

- **If we don’t agree** with some or all of your complaint or don't take responsibility for the problem you’re complaining about, we’ll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about MedMutual Advantage PPO directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:
Ending membership in our plan

Note: This chapter contains general information about disenrollment from a Medicare Advantage plan. For more information or for specific options available to you as a member of a group-sponsored plan, please contact your group benefits administrator.

SECTION 1 Ending your membership in our plan

Ending your membership in MedMutual Advantage PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. Contact your group's benefit administrator, or if so directed by that administrator, Customer Care, before you disenroll.

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of MedMutual Advantage 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 our plan, call Medicare, or visit (Medicare.gov).

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you.
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

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.

Enrollment time periods vary depending on your situation.

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

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan, *or*
- Original Medicare *without* a separate Medicare drug plan.
  Note: If you disenroll from Medicare 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 we get your request to change your plan.

If you get Extra Help from Medicare to pay your drug coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.2 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- Contact your group's benefits administrator or, if so directed by that administrator, Customer Care at 1-800-801-4823 (TTY users call 711).
- Find the information in the ***Medicare & You 2027*** handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from MedMutual Advantage PPO when your new plan's coverage starts.
Original Medicare with a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from MedMutual Advantage PPO when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Customer Care at 1-800-801-4823 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from MedMutual Advantage PPO when your coverage in Original Medicare starts.

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 starts, you must continue to get your medical items, services and prescription drugs through our plan.

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

SECTION 5 MedMutual Advantage PPO must end your plan membership in certain situations

MedMutual Advantage 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're away from our service area for more than 6 months
    - If you move or take a long trip, call your group's benefit administrator, or if so directed by that administrator, Customer Care at 1-800-801-4823 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If your group's benefit administrator determines you are no longer eligible for the plan.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership call your group's benefit administrator, or if so directed by that administrator, Customer Care at 1-800-801-4823 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

MedMutual Advantage PPO isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

If your group's benefit administrator determines you are no longer eligible for the plan, you will need to contact your group's benefit administrator.

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 (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call us at Customer Care at 1-800-801-4823 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-801-4823.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator, 100 American Road, Cleveland, OH 44144, call 1-800-382-5729 (TTY: 711), or email CivilRightsCoordinator@MedMutual.com. You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at: hhs.gov/ocr/office/file/index.html.

This notice is available at Medical Mutual's website: medmutual.com.

Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation or MedMutual Life Insurance Company.

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, MedMutual Advantage 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.

SECTION 4 Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will be null and void.

SECTION 5 Entire Contract

This *Evidence of Coverage* and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

SECTION 6 Waiver by Agents

No agent or other person, except an executive officer of Medical Mutual, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart in Chapter 4.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

SECTION 7 Consent to Release Medical Information

You consent to the release of medical information to Medical Mutual when you sign an application.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual. Medical Mutual has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

SECTION 8 Limitation of Actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than 3 years after the service upon which the legal action is based was provided.

SECTION 9 Plan's Sole Discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*. This applies if we determine such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

SECTION 10 Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition. The following apply:

You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.

The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and, pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.

If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

SECTION 11 Notice about recovery of overpayments

If the benefits paid by this *Evidence of Coverage*, plus the benefits paid by other plans, exceeds the total amount of expenses, our plan has the right to recover the amount of that excess payment from among one or more of the following: (1) any person to or for whom such payments were made; (2) other plans; or (3) any other entity to which such payments were made. This right of recovery will be exercised at our plan's discretion. You shall execute any documents and cooperate with us to secure our right to recover such overpayments, upon our request.

SECTION 12 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the patient's medical needs and condition;
    - Ordered and furnished by qualified personnel;
    - One that meets, but does not exceed, the patient's medical need; and
    - At least as beneficial as an existing and available medically appropriate alternative.

SECTION 13 Our contracting arrangements

We pay providers using various payment methods, including capitation, per diem, incentive and discounted fee-for-service arrangements. Capitation means paying an agreed upon dollar amount per month for each member assigned to the provider. Per diem means paying a fixed dollar amount per day for all services rendered, such as inpatient hospital and skilled nursing facility stays. Incentive means a payment that is based on appropriate medical management by the provider. Discounted fee-for-service means paying an agreed upon fee schedule which is a reduction from their usual and customary charges.

You are entitled to ask if we have special financial arrangements with the network providers that may affect the use of referrals and other services that you might need.

SECTION 14 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions. In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

SECTION 15 Presidential or Governor Emergencies

In the event of a Presidential or Governor emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, we will make the following exceptions to assure adequate care during the emergency:

Approve services to be furnished at specified non-contracted facilities that are considered Medicare-certified facilities; and

Temporarily reduce cost sharing for plan-approved, out-of-network services to the in-network cost-sharing amounts.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and if CMS has not indicated an end date to the disaster or emergency, we will resume normal operations 30 days from the initial declaration. When a disaster or emergency is declared, it is specific to a geographic location (i.e., county). We will apply the above exceptions only if you reside in the geographic location indicated.

CHAPTER 12: Definitions

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of MedMutual Advantage PPO, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services, and the way that our plan measures your use of mental health care services in a hospital and SNF services. Under our plan, a benefit period begins the day you go into a hospital for mental health care services or into a skilled nursing facility, and the benefit period ends when you have not received any inpatient hospital care for mental health (or skilled care in a SNF) for 60 days in a row. If you go into a hospital for mental health care services or into 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to **"Original Biological Product"** and **"Biosimilar"**.)

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription. (Go to **"Interchangeable Biosimilar"**).

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 $2,400 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.3, for information about your combined maximum out-of-pocket amount.

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 get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 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 gotten; 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 gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 6 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 our plan and the amount, if any, you're 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 our plan, that isn't a coverage determination. You need to call or write to our 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 the prescription drugs covered by our plan.

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

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

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

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

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're 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 our plan is 30 days, then your daily cost sharing rate is $1 per day.

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

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

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

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the 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 doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed

nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

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

Hospital Inpatient Stay – A hospital stay when you 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 won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't 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.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: **Institutional** equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

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

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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 FDA or supported by certain references, such as the American Hospital Formulary Service Drug information and the Micromedex DRUGDEX Information system.

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

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

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

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

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

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

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

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

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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).

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**.

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

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

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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 2 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 doesn't 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 aren't covered by our plan unless certain conditions apply.

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

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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

Part C – Go to 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 plan 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're first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

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 gotten from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from in-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.

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

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

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but aren't 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 a drug 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.

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

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

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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

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

Special Enrollment Period – A set time when members can change their health or drug 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're 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 live in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll 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 aren't the same as Social Security benefits.

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

PRESCRIPTION DRUG CERTIFICATE

Your Group plan is comprised of a Medicare Advantage Prescription Drug Plan that includes Medicare Part A and Part B coverage and additional benefits beyond what Medicare typically covers. This booklet describes these additional benefits and works in conjunction with your Medicare Advantage *Evidence of Coverage* and any Annual Notice of Change associated with your *Evidence of Coverage*.

This Certificate describes the Outpatient Prescription Drug coverage available to you as part of a Group Contract between Medical Mutual of Ohio ("Medical Mutual") and the employer or organization which pays or forwards the fees for this coverage, also referred to as the "Group." This Certificate is subject to the terms and conditions of the Group Contract. This is not a summary plan description or an Employee Retirement Income Security Act (ERISA) plan document by itself. However, it may be attached to a document prepared by your Group that is called a summary plan description.

Medical Mutual shall have the right to interpret and apply the terms of this Certificate. The decision about whether to pay any claim, in whole or in part, is within the discretion of Medical Mutual, subject to any available appeal process.

The benefits in this non-Medicare drug plan supplement the benefits paid by your Group's Medicare Part D Group Prescription Drug Plan (also known as the "Part D Group Plan"). Your Part D Group Plan may be combined with your Medicare medical coverage (Medicare Advantage Part C Plan).

All persons who meet the following criteria are covered by the Group Contract and are referred to as "**Certificate Holders," "you" or "your."** They must:

- apply for coverage under the Group Contract;
- pay for coverage if necessary;
- satisfy the conditions specified in the Eligibility section; and
- be approved by Medical Mutual.

If you have questions regarding this Certificate, please contact Customer Care at the phone number shown on your identification (ID) Card.

NOTICE:
IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Medical Mutual of Ohio (Medical Mutual)

SCHEDULE OF BENEFITS

This Schedule of Benefits reflects the costs you must pay after benefits are provided under this Certificate and your Part D Group Plan. Please refer to the Certificate that follows for additional information.

BENEFIT PERIOD

Benefit Period	Calendar year 01/01/2027 - 12/31/2027
Formulary	Closed

OUTPATIENT PRESCRIPTION DRUG BENEFIT FOR PART D COVERED DRUGS

Deductible per Benefit Period	$0

The following table shows the amounts you are responsible to pay after:

1. You have met your Deductible, if applicable; and
2. Benefits have been paid by your Part D Group Plan and this plan for Covered Drugs when you are in your Part D Group Plan's Initial Coverage phase.

To achieve the highest level of benefits under this plan, use Preferred Retail Pharmacies. You can find a list of Preferred Retail Pharmacies in your pharmacy directory. You can also contact a Customer Service Representative for additional information.

SCHEDULE OF BENEFITS

Retail Pharmacy Benefit	Up to a 90-day supply	
Standard Network Pharmacy	**30-day supply**	**90-day supply**
Tier 1: Preferred Generics	$10 copayment	$25 copayment
Tier 2: Generics	$10 copayment	$25 copayment
Tier 3: Preferred Brands and Generics	20% coinsurance ($25 min./$75 max.)	20% coinsurance ($65 min./$155 max.)
Tier 4: Non-Preferred Drugs	40% coinsurance ($40 min./$150 max.)	40% coinsurance ($95 min./$305 max.)
Tier 5: Specialty Drugs (Generic and Brand)	40% coinsurance ($40 min./$150 max.)	40% coinsurance ($95 min./$305 max.)
Tier 6: Select Care Drugs	$10 copayment	$25 copayment

Retail Pharmacy Benefit	Up to a 90-day supply	
Preferred Network Pharmacy	**30-day supply**	**90-day supply**
Tier 1: Preferred Generics	$0 copayment	$0 copayment
Tier 2: Generics	$5 copayment	$10 copayment
Tier 3: Preferred Brands and Generics	15% coinsurance ($20 min./$70 max.)	15% coinsurance ($60 min./$150 max.)
Tier 4: Non-Preferred Drugs	35% coinsurance ($35 min./$145 max.)	35% coinsurance ($90 min./$300 max.)
Tier 5: Specialty Drugs (Generic and Brand)	35% coinsurance ($35 min./$145 max.)	35% coinsurance ($90 min./$300 max.)
Tier 6: Select Care Drugs	$0 copayment	$0 copayment

Home Delivery Pharmacy	Preferred Mail-Order Pharmacy per 90-day supply	Standard Mail-Order Pharmacy per 90-day supply
Tier 1: Preferred Generics	$0 copayment	$25 copayment
Tier 2: Generics	$10 copayment	$25 copayment
Tier 3: Preferred Brands and Generics	15% coinsurance ($60 min./$150 max.)	20% coinsurance ($65 min./$155 max.)
Tier 4: Non-Preferred Drugs	35% coinsurance ($90 min./$300 max.)	40% coinsurance ($95 min./$305 max.)
Tier 5: Specialty Drugs (Generic and Brand)	35% coinsurance ($90 min./$300 max.)	40% coinsurance ($95 min./$305 max.)
Tier 6: Select Care Drugs	$0 copayment	$25 copayment

Additional Covered Drugs: Cough and cold; vitamins and minerals; erectile dysfunction; antihistamines; diabetic supplies without syringe; anti-obesity; and serotonin 5 HT-receptor agonists (Addyi)	These drugs are excluded by law from Part D plans, but they are covered under your Part D Group Plan and this plan.			
	Preferred Network Retail Pharmacy 30-day supply	**Preferred Network Retail Pharmacy 90-day supply**	**Standard Network Retail Pharmacy 30-day supply**	**Standard Network Retail Pharmacy 90-day supply**
Generics	$5 copayment	$10 copayment	$10 copayment	$25 copayment
Brands (single source)	15% coinsurance ($20 min./$70 max.)	15% coinsurance ($60 min./$150 max.)	20% coinsurance ($25 min./$75 max.)	20% coinsurance ($65 min./$155 max.)
Brands (multi-source)	35% coinsurance ($35 min./$145 max.)	35% coinsurance ($90 min./$300 max.)	40% coinsurance ($40 min./$150 max.)	40% coinsurance ($95 min./$305 max.)

Additional Covered Drugs: Cough and cold; vitamins and minerals; erectile dysfunction; antihistamines; diabetic supplies without syringe; anti-obesity; and serotonin 5 HT-receptor agonists (Addyi)	These drugs are excluded by law from Part D plans, but they are covered under your Part D Group Plan and this plan.	
	Preferred Mail Order Pharmacy 90-day supply	**Standard Mail Order Pharmacy 90-day supply**
Generics	$10 copayment	$25 copayment
Brands (single source)	15% coinsurance ($60 min./$150 max.)	20% coinsurance ($65 min./$155 max.)
Brands (multi-source)	35% coinsurance ($90 min./$300 max.)	40% coinsurance ($95 min./$305 max.)

After the amount you pay for Covered Drugs reaches **$1,000** in a Benefit Period, you will no longer have to pay a copay or Coinsurance for Covered Drugs until the next Benefit Period begins.

HOW TO USE YOUR CERTIFICATE

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage and explains your Coinsurance, Copayment and Deductible obligations, if applicable.

The **Definitions** section will help you understand unfamiliar words and phrases. If a word or phrase starts with a capital letter, it is either a title or it has a special meaning. If the word or phrase has a special meaning, it will be defined in this section or where used in the Certificate.

The **Eligibility** section outlines how and when you become eligible for coverage under the Contract and when this coverage starts.

The **Outpatient Prescription Drug Benefit** section explains your benefits and some of the limitations on the Covered Services available to you.

The **Exclusions** section lists services which are not covered.

The **General Provisions** section explains how benefits are paid, how Coordination of Benefits works, and when your coverage stops.

DEFINITIONS

Additional Covered Drugs - drugs that are excluded by law from coverage by Medicare Part D, but are included in some drug plans that supplement Medicare Part D. If your plan covers these Additional Covered Drugs, they will be listed in the Schedule of Benefits.

Allowed Amount - For Network Pharmacies, the Allowed Amount is the lesser of the applicable Prescription Drug Negotiated Amount or the Billed Charges for Covered Drugs. For non-Network Pharmacies, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Billed Charges.

Annual Notice of Change - a document that describes significant changes that are being made to the Medicare Advantage *Evidence of Coverage* for the upcoming year.

Benefit Period - the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, and out-of-pocket maximums are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the effective date and the date your coverage terminates.

Billed Charges - the amount billed on the claim submitted by the Provider for services and supplies provided to a Certificate Holder.

Brand Name Drug (also called "Brand Drugs") - 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 not available until after the patent on the Brand Name Drug has expired.

Certificate - this document.

Certificate Holder - an eligible employee, Retiree or participant of the Group who has enrolled for coverage under the terms and conditions of the Group Contract.

Coinsurance - a percentage of the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible or paid your Copayment, if applicable.

Condition - an injury, ailment, disease, illness or disorder.

Contract - the agreement between Medical Mutual and your Group referred to as the Group Contract. The Contract includes the Group Application, individual Applications of the Certificate Holders, this Certificate, Schedules of Benefits and any Riders or amendments.

Contracting Home Delivery Pharmacy - a Pharmacy which dispenses Prescription Drugs through the mail and which has a contractual obligation with Medical Mutual to provide services.

Contracting Specialty Pharmacy - a Pharmacy which dispenses Specialty Prescription Drugs and which has a contractual obligation with Medical Mutual to provide services.

Copayment (also called "Copay") - a dollar amount, if specified in the Schedule of Benefits, that you may be required to pay at the time Covered Services are rendered.

Covered Drugs (also called "Covered Services") - those Prescription Drugs for which Medical Mutual will provide benefits under this plan.

Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before Medical Mutual will start to provide benefits.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure (also called "Experimental or Investigational") - a drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and
- approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;

- opinions expressed by expert consultants retained by Medical Mutual to evaluate requests for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
- corporate medical policies developed by Medical Mutual; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, Medical Mutual will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that Medical Mutual would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by Medical Mutual in its sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

***Evidence of Coverage* -** a booklet that provides details about health care and/or prescription drug coverage under a Medicare Advantage plan.

Formulary - a list of Generic Prescription Drugs, Brand Name Prescription Drugs and over-the-counter drugs that are covered under this plan.

Generic Drug (also called "Generic") - a Prescription Drug that is approved by the Food and Drug Administration (FDA) and is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted and will produce comparable effective clinical results.

Group Contract - the contract between the Group and Medical Mutual.

Group Medicare Prescription Drug Plan (also called "Medicare Part D Group Plan" or "Part D Group Plan") - Medicare Prescription Drug plan sold to employers or unions to offer to their Medicare-eligible employees and/or Retirees. Also see "Medicare Prescription Drug Plan" definition.

Home Delivery Prescription Drug - a Prescription Drug which can be provided by a Home Delivery Pharmacy.

Hospital - an accredited Institution that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code and any other regional, state or federal licensing requirements, except for the requirement that such Institution be operated within the state of Ohio.

Inpatient - a Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

Lifestyle Drug - a drug that is used to improve quality of life, as opposed to a drug taken to cure or manage an illness. Please refer to the Schedule of Benefits to determine if your plan includes these drugs.

Medically Necessary (also called "Medical Necessity") - a Covered Service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which Medical Mutual determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

Medicare - the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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 HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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 Part D Eligible Drug - Subject to certain exclusions, a Medicare Part D Eligible Drug is a drug dispensed only upon a Prescription, used for a medically-accepted indication, approved by the Food and Drug Administration, and used and sold in the United States. Medicare Part D Eligible Drugs include outpatient Prescription Drugs, biological products, insulin, medical supplies associated with the injection of insulin and certain vaccines.

Medicare Prescription Drug Plan (also called "Medicare Part D Plan" or "Part D Plan") - insurance to help pay for outpatient Prescription Drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Network Pharmacy - a Pharmacy that has a network agreement to provide Prescription Drug services.

Non-Contracting Amount - an amount that is based on the lesser of the Billed Charges or an amount similar to or less than what Medical Mutual would pay a Network Pharmacy.

Open Enrollment - a period of enrollment designated by the Group and the plan in which eligible employees and/or Retirees can enroll without penalty after the initial enrollment. See "Eligibility" section for more information.

Pharmacy - a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

Physician - a person who is licensed and legally authorized to practice medicine.

Preferred Brand Name Prescription Drug (also called "Preferred Brand Drug") - a Brand Name Prescription Drug that is included in Medical Mutual's Formulary and is classified as "Preferred."

Preferred Cost-sharing - Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Retail Pharmacy - a retail Pharmacy that has a contract with Medical Mutual to provide Outpatient Prescription Drugs at negotiated rates. Certificate Holders pay a lower cost when they use one of these Pharmacies. Please refer to the Schedule of Benefits to determine if these Pharmacies are included in this plan.

Prescription Drug (also called "Federal Legend Drug") - any medication that by federal or state law may not be dispensed without a Prescription Drug Order.

Prescription Drug Negotiated Amount - the amount the Pharmacy has agreed to accept as payment in full for Covered Services. The Prescription Drug Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings (rebates), volume based credits or refunds or discount guarantees. In certain circumstances, Medical Mutual may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Pharmacy instead of Medical Mutual contracting directly with the Pharmacy itself. In these circumstances, the Prescription Drug Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon the vendor's actual negotiated price with the Pharmacy, subject to the further conditions and limitations set forth herein.

Prescription Drug Order - the request for medication by a Physician or other Professional Provider who is licensed by his or her state to make such a request in the ordinary course of professional practice.

Prior Authorization (also called "Preauthorization") – a program applied to certain Prescription Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prior Authorization helps promote appropriate use and enforcement of medically accepted guidelines for Prescription Drug benefit coverage.

Prior Authorization is required for most Specialty Prescription Drugs and may also be required for certain other Prescription Drugs (or the prescribed quantity of a certain Prescription Drug).

Provider - a person or organization responsible for furnishing Health Care Services, including a hospital, skilled nursing facility, rehabilitation facility, ambulatory surgery center or Physician.

Quantity Limits - Certain Prescription Drugs are covered only up to a certain limit. Quantity Limits help promote appropriate dosing of Prescription Drugs and enforce medically accepted guidelines for Prescription Drug benefit coverage. Obtaining quantities beyond the predetermined limit requires Prior Authorization.

Recovery - money you receive from another, his or her insurer, or from any uninsured motorist, underinsured motorist, medical payments, no-fault or personal injury protection or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Recovery provisions of this plan.

Retiree - former employee of the employer or member of a union who is entitled to participate in the retiree benefit plan arranged by the employer or union and who is enrolled in or enrolling in Medicare.

Rider - a document that amends or supplements your coverage.

Special Enrollment - a period of enrollment in which certain eligible employees and/or Retirees can enroll after the initial enrollment.

Specialty Prescription Drugs (also called "Specialty Drugs") - a Prescription Drug that:

- is approved only to treat limited patient populations, indications or Conditions; and
- is normally, but not always, injected, infused or requires close monitoring by a Physician or clinically trained individual and meets one of the following:
- the FDA has restricted distribution of the drug to certain facilities or Providers; or
- requires special handling, provider coordination or patient education that cannot be met by a retail Pharmacy.

Stabilize - with respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

Standard Cost-sharing - Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy - a program to determine whether you qualify for coverage based upon certain information, such as medical history, drug history, age and gender. This program requires that you try another drug before the target drug will be covered under this plan, unless special circumstances exist. If your Physician believes that special circumstances exist, he or she may request a coverage review.

ELIGIBILITY

In order to enroll for coverage under this plan, you must:

- Be entitled to or enrolled in Medicare Part A and/or enrolled in Medicare Part B.
- Be entitled to participate in the benefit plan arranged by the Group for Medicare-eligible employees and/or Retirees. In order to participate in the Group's Medicare plan, certain requirements must be satisfied. For more specific eligibility information, you should contact the Group's benefit administrator.
- Be eligible for the Medicare Part D Group Plan that is offered by the Group

Notification of Eligibility Change

You must notify your Group's Benefit Administrator or Medical Mutual of any changes that affect your eligibility for coverage under this Certificate as quickly as possible but, in no event, later than thirty-one (31) days of the event. Failure to provide Medical Mutual with proper and timely notification of persons no longer eligible will not obligate Medical Mutual to provide benefits for services provided to such persons. Medical Mutual has the right to bill the Certificate Holder for the cost of any services provided to such person during the period such person was not eligible for coverage.

Enrollment Periods

Within thirty-one (31) days of your eligibility date. You can enroll in this plan when you are first eligible if you are already enrolled in, or are concurrently enrolling in, the Part D Group Plan that is also part of the group benefit plan arranged by the Group for Medicare-eligible employees and/or Retirees.

It is important that you enroll in this plan when you first become eligible (within thirty-one (31) days of your eligibility date). Otherwise, you may only be able to enroll for coverage during a Special Enrollment period or during an Open Enrollment period, described further below. Please contact your Group's Benefit Administrator for additional information.

Special Enrollment

If you declined the coverage provided by this Certificate when you were initially eligible because of having other coverage, and you lose that coverage, you may be eligible to enroll under this plan if you submit a completed application to us within thirty-one (31) days of that other coverage ending. The application must certify that you had other coverage at the time you were eligible to enroll under the Policy and that having other coverage was the reason for declining enrollment under the Policy.

Open Enrollment

If your Group offers an annual Open Enrollment period, and the coverage provided by this Certificate was declined at the time of initial eligibility or during Special Enrollment, you may apply for coverage during the annual Open Enrollment period. Please contact your Group's Benefit Administrator for further information.

Effective Dates

After Medical Mutual receives your enrollment application, whether submitted when you are first eligible, during a special enrollment period, or during an open enrollment period, coverage will become effective on the later of: 1) the effective date requested on the application; or 2) the first day of the month after Medical Mutual receives your application. Please note that the effective date of coverage under this plan may not be prior to the effective date of the Part D Group Plan which this plan supplements.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

This plan supplements the benefits provided by the Medicare Part D group plan you have through your current or former employer. If your Part D Group Plan covers a Medicare Part D Eligible Drug, this plan will supplement that plan's benefits up to, but not including, the Deductible, Coinsurance or Copay amounts shown in this plan's Schedule of Benefits.

This plan may also provide benefits for other drugs that are not covered by your Medicare Part D Group Plan. These are referred to as "Additional Covered Drugs." If this plan provides benefits for Additional Covered Drugs, and one or more of those drugs has recently been approved by the FDA, such drugs will not be covered until Medical Mutual establishes criteria for Medically Necessary prescriptions. These criteria may be established at approximately six months after the FDA approval. Some Prescription Drugs approved by the FDA may never qualify as Medically Necessary.

Your Medicare Part D Group Plan is the primary payer for all covered Medicare Part D Eligible Drugs. That plan determines whether a particular drug is covered or whether it is subject to coverage management programs. When this plan provides benefits for "Additional Covered Drugs," these additional drugs are subject to Quantity Limits and Step Therapy programs. More information on these programs will be sent to you along with your prescription drug benefit member material. You can also contact Customer Care for details.

The Certificate Holder is responsible for any Copayment, Coinsurance or Deductible amounts specified in the Schedule of Benefits. The amount you pay in Copayments or Coinsurance may vary, depending upon the tier in which your drug is covered. The identification card you receive can be used for both your Medicare Part D Group Plan and this plan. Present the card to your pharmacist when you're filling a prescription.

In most cases, your drugs are covered **only** if they are filled at a Network Pharmacy. If you have them filled at a non-Network Pharmacy, you will need to pay the full cost of your Outpatient drug(s). You can send us a request to reimburse you for our share of the cost by providing your name, address, group and subscriber numbers, your receipt reflecting the Outpatient drug(s) received and your payment. Contact our Customer Care department if you need any assistance.

This plan covers only those drugs included on our formulary.

Home Delivery program

Benefits for Home Delivery Prescription Drugs provide the convenience of receiving Prescription Drugs delivered directly to your home. A Home Delivery Prescription Drug is a Prescription Drug which can be provided by a Contracting Home Delivery Pharmacy and must be taken for an extended period of time in order to treat a certain medical Condition.

You will be responsible for paying any applicable Copayment, Deductible or Coinsurance shown on the Schedule of Benefits.

EXCLUSIONS

This plan does not provide benefits for:

- Drugs not covered by your Part D Group Plan, unless covered under the "Additional Covered Drugs" benefit.
- Drugs covered under Medicare Part A or Part B.
- Costs you pay towards meeting your Copayment, Deductible, or Coinsurance, if applicable.
- Non-prescription drugs (also called over-the-counter drugs).
- Drugs when used for treatment of anorexia or weight gain, unless used to treat HIV and Cancer wasting.
- Drugs when used for cosmetic purposes or to promote hair growth.
- 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.
- Experimental or Investigational Drugs.
- Drugs when used to promote fertility.
- Non-Part D syringes.
- Any charge for the administration of a prescription drug.
- Certain immunization agents, vaccines, biological sera, blood or blood plasma.
- Devices and supplies (except insulin needles and syringes) of any type including, but not limited to, therapeutic devices, artificial appliances, support garments, and contraceptive devices.
- Drugs or medications which do not require a prescription.
- Total parenteral nutrition (TPN).
- Drugs not on the Formulary.

GENERAL PROVISIONS

Notice of Claim

The Pharmacy filling your Prescription will generally submit the claim for you. However, if that does not occur, send us your request for payment, along with your bill and documentation of any payment you have made. This proof of claim must be given to us within 90 days from the date you filled your prescription, or as soon as reasonably possible. Except in the absence of legal capacity, no proof can be submitted later than one year from the time proof is otherwise required. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (MedMutual.com/Member) or call Customer Care and ask for the form.

Contact Customer Care if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Benefits will be provided under this Certificate within thirty (30) days after we receive a completed claim, or as otherwise required under Medicare Laws and Regulations. If supporting documentation is required, payment will be made in accordance with state and federal laws.

Complaints and appeals

If you have a problem or concern with your benefits under this plan or with the services we provide, first contact Customer Care. Our Customer Care Specialists are trained in Medicare Advantage plans and are here to help you.

If you need additional assistance, there are detailed complaint and appeal processes that have been approved by Medicare for handling problems and concerns. You can find more information on these processes in the Medicare Advantage *Evidence of Coverage* you receive from us. If you need another copy of your *Evidence of Coverage*, or have questions on what steps to follow, please contact Customer Care.

Cooperation of Certificate Holder

Each Certificate Holder must complete and submit to Medical Mutual any such authorizations, consents, releases, assignments and other documents that may be requested by Medical Mutual, in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Certificate Holder who fails to cooperate (including failing to enroll under Part B and/or Part D of Medicare where Medicare is the responsible payer) will be responsible for any charge for services.

Claim Review

You consent to the release of medical information to Medical Mutual when you sign an application. When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual. Medical Mutual has the right to refuse to reimburse for covered services if you refuse to consent to the release of any medical information.

Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan. Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

Definitions

- A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same plan, and there is no COB among those separate Contracts.
    - **Plan** includes: group and non-group insurance Contracts, health insuring corporation ("HIC") Contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care Contracts, such as skilled nursing care; medical benefits under group or individual automobile Contracts; and Medicare or any other federal governmental plan, as permitted by law.
    - **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

      Each Contract for coverage under "a" or "b" above is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.
- **This Plan** means, in a **COB** provision, the part of the Contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the Contract providing health care benefits is separate from This Plan. A Contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.
- The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

  When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable Expense.**
- **Allowable Expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable Expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable Expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Certificate Holder is not an **Allowable Expense**.

The following are examples of expenses that are not **Allowable Expenses:**

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an **Allowable Expense**, unless one of the **Plans** provides coverage for private Hospital room expenses.
- If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable Expense**.
- If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable Expense**.
- If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable Expense** for all **Plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable Expense** used by the **Secondary plan** to determine its benefits.
- The amount of any benefit reduction by the **Primary plan** because a Certificate Holder has failed to comply with the **Plan** provisions is not an **Allowable Expense**. Examples of these types of plan provisions include second surgical opinions, Preauthorization of admissions, and preferred provider arrangements.

- **Closed Panel Plan** is a **Plan** that provides health care benefits to Certificate Holders primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

1. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph "b" below, a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the Contract Holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed Panel Plan** to provide out-of-network benefits.

3. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
    a. Non-Dependent or Dependent. The **Plan** that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or Retiree, is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a Dependent, and primary to the **Plan** covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or Retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
    b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order of benefits is determined as follows:
        1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
            - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan.**
            - However, if one parent's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
        2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
            b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
            c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
            d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
                - The **Plan** covering the **Custodial parent**;
                - The **Plan** covering the spouse of the **Custodial parent**;
                - The **Plan** covering the **non-custodial parent**; and then
                - The **Plan** covering the spouse of the **non-custodial parent**.

1. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

a. Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

b. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or Retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

c. Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or Retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

d. If the preceding rules do not determine the order of benefits, the **Allowable Expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

Effect on the Benefits of This plan

1. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable Expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable Expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable Expense** for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
2. If a Certificate Holder is enrolled in two or more **Closed Panel Plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed Panel Plan**, **COB** shall not apply between that **Plan** and other **Closed Panel Plans**.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. Medical Mutual may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. Medical Mutual need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Medical Mutual any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, Medical Mutual may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. Medical Mutual will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Medical Mutual is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Certificate Holder. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at (800) 700-2583 or MedMutual.com. In the event our phone number or website changes, refer to your identification card for the most current information. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (800) 686-1526, or visit the Department's website at http://insurance.ohio.gov.

Subrogation and Right of Reimbursement
As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care or treatment of Third Party Injuries. No adult Certificate Holder hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Certificate Holder without the prior express written consent of Medical Mutual.

If this plan pays benefits under this Certificate to you for expenses incurred due to Third Party Injuries, then Medical Mutual retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the Third Party Injuries. Medical Mutual's rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Pharmacy payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate you for injuries resulting from an accident, injury or alleged negligence.

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

By accepting benefits under this plan, you specifically acknowledge Medical Mutual's right of subrogation. When this plan pays health care benefits for expenses incurred due to Third Party Injuries, Medical Mutual shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. Medical Mutual may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge Medical Mutual's right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to Third Party Injuries and you or your representative has recovered any amounts from a Third Party. By providing any benefit under this Certificate, Medical Mutual is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. Medical Mutual's right of reimbursement is cumulative with, and not exclusive of, Medical Mutual's subrogation right and Medical Mutual may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you and your representatives further agree to:

- Notify Medical Mutual promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by you;
- Cooperate with Medical Mutual and do whatever is necessary to secure Medical
- Mutual's rights of subrogation and reimbursement under this Certificate;
- Give Medical Mutual a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party Injuries provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Medical Mutual as reimbursement for the full cost of all benefits associated with Third Party Injuries paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement); and
- Do nothing to prejudice Medical Mutual's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of Third Party Injuries.

No court costs or attorney fees may be deducted from Medical Mutual's recovery, and Medical Mutual is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any Third Party. In the event you or your representative fail to cooperate with Medical Mutual, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by Medical Mutual in obtaining repayment.

Medical Mutual's rights of subrogation and reimbursement described above shall be modified to comply with the terms of this paragraph in the event that less than the full value of the third party action is recovered due to comparative negligence on your part, diminishment of the recovery due to the apportionment of liability among and recovery on judgment against multiple co-defendants, or by reason of the collectability of the full value of the claim for injury, death, or loss to you resulting from limited liability insurance or any other cause. If less than the full value of the third party action is recovered due the reasons mentioned in the preceding sentence, Medical Mutual's claim shall be reduced in the same proportion as your interest is reduced. Both Medical Mutual and the member shall have the right to seek a declaratory judgment pursuant to ORC Section 2721 if there is a dispute over the distribution of the recovery in a tort action.

Changes in Benefits or Provisions

The benefits provided by this coverage may be changed at any time. It is your Group's responsibility to notify you when these changes go into effect. If the provisions of this Certificate are changed or revised by Medical Mutual, Medical Mutual will notify the Group at least thirty-one (31) days prior to the changes becoming effective. It is the responsibility of the Group to notify the Certificate Holders of the change or revision.

No change in this Contract will be effective until approved in writing by an authorized officer of Medical Mutual. No agent, employee or representative of Medical Mutual, other than an authorized officer, may change this Contract or waive any of its provisions.

How and When Your Coverage Stops

- By termination of the Group Contract including termination for non-payment. This automatically ends all of your coverage. It is the responsibility of your Group to notify you of such termination.
- At the end of the month that coverage under the Part D Group plan which this plan supplements ends, whether you voluntarily or involuntarily terminate your Part D Group plan.
- At the end of the month that the Certificate Holder becomes ineligible.
- At the end of the period for which the premium was made when a Certificate Holder does not pay the next required contribution.
- If an Open Enrollment period is offered by the Group for this coverage, the Certificate Holder may voluntarily terminate coverage effective as of the renewal date of the Group's plan.
- Immediately upon notice if:
    - a Certificate Holder allows a non-covered person to use his/her identification card to obtain or attempt to obtain benefits; or
    - a Certificate Holder intentionally misrepresents a material fact provided to Medical Mutual or commits fraud or forgery.

Continuation of Coverage

If you no longer qualify for coverage under this plan, you may be able to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under state continuation laws. Please contact your HR Benefit Administrator prior to coverage ending under this plan, for additional information.

Legal Actions

No action, at law or in equity, shall be brought to recover benefits within sixty (60) days after Medical Mutual receives written proof in accordance with this Certificate that Covered Services have been given to you. No such action may be brought later than three (3) years after expiration of the required claim filing limit, as specified in the Notice of Claim section.

Direction of Payment to Providers

Medical Mutual is authorized to make payments directly to Providers who have performed Covered Services for you. Any payments made by Medical Mutual will discharge Medical Mutual's obligation to pay for Covered Services.

Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider, and Medical Mutual is not legally obligated to pay any additional amounts.

You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

If Medical Mutual has incorrectly paid for services, or it is later discovered that payment was made for services that are not considered Covered Services, Medical Mutual has the right to recover payment, and you must repay this amount when requested.

APPENDIX 1 State Health Insurance Assistance Programs (SHIPs)

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Alabama	State Health Insurance Assistance Program (SHIP) Alabama Department of Senior Services 201 Monroe St., Suite 350 Montgomery, AL 36104 www.alabamaageline.gov/ship/	1-800-243-5463
Alaska	The Medicare Savings Program (MSP) Alaska Department of Health Medicare Information Office 3601 C Street, Suite 902 Anchorage, AK 99503 https://health.alaska.gov	1-800-478-6065 TTY: 1-800-770-8973
Arizona	State Health Insurance Assistance Program (SHIP) Individuals should contact the SHIP office in the county in which they reside. https:// azship.org	1-800-432-4040
Arkansas	Senior Health Insurance Information Program (AR SHIIP) Arkansas Insurance Department One Commerce Way Little Rock, AR 72202 https://www.shiipar.com	1-800-224-6330
California	State Health Insurance Assistance Program (SHIP) California Health Insurance Counseling and Advocacy Program (HICAP) https://www.aging.ca.gov/hicap/	1-800-434-0222
Colorado	Senior Health Insurance Assistance Program (SHIP) Division of Insurance Colorado Department of Regulatory Agencies 1560 Broadway, Suite 850 Denver, CO 80202 https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	1-888-696-7213
Connecticut	The CHOICES Program - Connecticut Health insurance assistance, Outreach, Information and referral, Counseling and Eligibility Screening Aging and Disability Services 55 Farmington Ave., 12th Floor Hartford, CT. 06105 https://portal.ct.gov/ADS-CHOICES	1-800-994-9422
Delaware	Delaware Medicare Assistance Bureau (DMAB) https://insurance.delaware.gov/divisions/dmab	1-800-336-9500
District of Columbia	DC State Health Insurance Assistance Program (SHIP) InsuHealth Insurance Assistance 500 K Street, NE Washington, D.C. 20002 https://dacl.dc.gov/service/health-insurance-counseling	1-202-727-8370

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State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Florida	Serving Health Insurance Needs of Elders (SHINE) Program Florida Department of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399-7000 https://www.floridashine.org	1-800-963-5337 TTY: 1-800-955-8770
Georgia	Georgia SHIP Georgia Department of Human Services' (DHS) Division of Aging Services (DAS) State Health Insurance Assistance Program 47 Trinity Ave. S.W. Atlanta, GA. 30334 https://aging.georgia.gov/georgia-ship	1-866-552-4464 (Option #4) Monday through Friday, 8 a.m. – 5 p.m.
Guam	Guam Medicare Assistance Program (GUAM MAP) – State Health Insurance Assistance Program (SHIP) https://dphss.guam.gov/	1-671-735-7415 1-671-735-7421
Hawaii	Hawaii State Health Insurance Assistance Program (SHIP) Hawaii State Department of Health Executive Office on Aging – No. 1 Capitol District 250 South Hotel St., Suite 406 Honolulu, HI 96813-2831 https://www.hawaiiship.org	1-808-586-7299 Toll Free 1-888-875-9229
Idaho	Senior Health Insurance Benefits Advisors (SHIBA) – Idaho Department of Insurance 700 West State St., 3rd Floor P.O. Box 83720 Boise, ID 83720-0043 https://www.shiba.idaho.gov	1-800-247-4422 Monday through Friday, 8 a.m. to 5 p.m.
Illinois	Senior Health Insurance Program (SHIP) One Natural Resources Way, #100 Springfield, IL. 62702-1271 https://www.illinois.gov/aging/ship	1-800-252-8966 TTY: 711 (TRS)
Indiana	State Health Insurance Assistance Program (SHIP) 311 W. Washington St. Indianapolis, IN 46204 https://www.in.gov/ship	1-800-452-4800
Iowa	Senior Health Insurance Information Program SHIIP-SMP https://shiip.iowa.gov	1-800-351-4664 TTY: 1-800-735-2942

Appendix 1: State Health Insurance Assistance Programs (SHIPs)

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Kansas	Senior Health Insurance Counseling for Kansas (SHICK) Kansas Department for Aging and Disability Services New England Building 503 South Kansas Ave. Topeka, KS 66603-3404 https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick	1-800-860-5260
Kentucky	State Health Insurance Assistance Program (SHIP) Kentucky Cabinet for Health and Family Services Department for Aging and Independent Living Office of the Secretary 275 East Main St., 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 (Option #2)
Louisiana	Senior Health Insurance Information Program (SHIIP) 1702 N. Third St. P.O. Box 94214 Baton Rouge, LA 70802 https://www.ldi.la.gov/consumers/senior-health-shiip	1-800-259-5300
Maine	Maine State Health Insurance Assistance Program (SHIP) Maine Department of Health and Human Services 109 Capital Street 11 State House Station Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-800-262-2232 (SHIP) 1-877-353-3771 (ADRC)
Maryland	State Health Insurance Assistance Program (SHIP) Maryland Department of Aging 301 West Preston St., Suite 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425
Massachusetts	Serving Health Information Needs of Elders (SHINE) https://www.mass.gov/health-insurance-counseling	1-800-243-4636 TTY/ASCII: (800)-439-2370
Michigan	Michigan Medicare Assistance Program (MMAP, Inc.) https://www.mmapinc.org	1-800-803-7174
Minnesota	Minnesota Senior LinkAge Line 540 Cedar St. St. Paul, MN 55164 https://mn.gov/senior-linkage-line/	1-800-333-2433

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Mississippi	State Health Insurance Assistance Program (SHIP) Mississippi Department of Human Services Division of Aging & Adult Services 200 S. Lamar St. Jackson, MS 39201 https://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program	1-844-822-4622 (SHIP) 1-601-359-4500
Missouri	Missouri SHIP, State Health Insurance Assistance Program (SHIP) https://www.missouriship.org	1-800-390-3330
Montana	Montana State Health Insurance Assistance Program (SHIP) https://dphhs.mt.gov/sltc/aging/SHIP	1-800-551-3191
Nebraska	Nebraska Senior Health Insurance Information Program (SHIIP) Nebraska Department of Insurance 2717 S. 8th St., Suite 4 Lincoln, NE 68508 https://doi.nebraska.gov/ship	1-800-234-7119
Nevada	Nevada Medicare Assistance Program (MAP) 1550 E. College Parkway Carson City, NV 89706 https://www.nevadacareconnection.org/medicare-assistance-program-map	1-800-307-4444
New Hampshire	New Hampshire State Health Insurance Assistance Program (SHIP)https://www.dhhs.nh.gov	1-866-634-9412
New Jersey	State Health Insurance Assistance Program (SHIP) New Jersey Department of Human Services Division of Aging Services https://www.state.nj.us/humanservices/doas/services/ship/	1-800-792-8820
New Mexico	New Mexico ADRC – State Health Insurance Assistance Program (SHIP) New Mexico Aging & Long-Term Services Dept. 2550 Cerrillos Road Santa Fe, NM 87505 https://aging.nm.gov	1-800-432-2080 TTY: 1-505-476-4937
New York	Health Insurance Information Counseling and Assistance Program (HIICAP) https://aging.ny.gov/health-insurance-information-counseling-and-assistance	1-800-701-0501

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State	**Address/Website**	**Phone**
North Carolina	Medicare and Seniors' Health Insurance Information Program (SHIIP) North Carolina Department of Insurance 3200 Beechleaf Court Raleigh, NC 27604 https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip.	1-855-408-1212
North Dakota	North Dakota Insurance Department State Health Insurance Assistance Program (SHIP) 600 E. Boulevard Ave. Bismarck, ND 58505 https://www.insurance.nd.gov/consumers/medicare	1-888-575-6611
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP) Ohio Department of Insurance 50 West Town St., 3rd Floor, Suite 300 Columbus, OH 43215 https://insurance.ohio.gov/ consumers/medicare/01-oshiip	1-800-686-1578 Monday through Friday 7:30 a.m.- 5 p.m.
Oklahoma	Senior Health Insurance Counseling Program (SHIP) Oklahoma Insurance Department 400 NE 50th St. Oklahoma City, OK 73105 https://www.oid.ok.gov	1-800-763-2828
Oregon	Senior Health Insurance Benefits Assistance (SHIBA) https://shiba.oregon.gov	1-800-722-4134
Pennsylvania	Pennsylvania Medicare Education and Decision Insight – (PA MEDI) https://www.pa.gov/agencies/aging/aging-programs-and-services/pa-medi-medicare-counseling	1-800-783-7067 Monday through Friday 8 a.m. to 5 p.m.
Puerto-Rico	State Health Insurance Assistance Program SHIP https://agencias.pr.gov/ship	1-877-725-4300 TTY: 787-919-7291
Rhode Island	Rhode Island State Health Insurance Assistance Program (SHIP) Rhode Island Department of Human Services Office of Healthy Aging 25 Howard Ave. Building 57 Cranston, RI 02920 https://oha.ri.gov/medicare	1-888-884-8721 TTY: 1-401-462-0740
South Carolina	State Health Insurance Assistance Program (SHIP) 1301 Gervais St., Suite 350 Columbia, SC 29201 https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid	1-800-868-9095

State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
South Dakota	Senior Health Information and Insurance Education (SHIINE) https://www.shiine.net	Eastern South Dakota: 1-800-536-8197 Central South Dakota: 1-877-331-4834 Western South Dakota: 1-877-286-9072
Tennessee	Tennessee State Health Insurance Assistance Program (SHIP) https://tn.gov/aging/ship	1-877-801-0044
Texas	Texas Health Information, Counseling, and Advocacy Program (HICAP) https://www.hhs.texas.gov/services/health/medicare	1-800-252-9240
US Virgin Islands	The Virgin Islands State Health Insurance Assistance Program (VI SHIP) https://ltg.gov.vi/departments/vi-ship-medicare	1-340-773-6449 (St. Croix) 1-340-774-2991 (St. Thomas/St. John)
Utah	State Health Insurance Program (SHIP) Aging and Adult Services of Utah https://daas.utah.gov/seniors/	1-800-541-7735
Vermont	State Health Insurance Assistance Program (SHIP) – Vermont Association for Area Agencies on Aging https://asd.vermont.gov/services/ship	1-800-642-5119
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP) Virginia Division for the Aging 1610 Forest Ave., Suite 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402
Washington	Office of the Insurance Commissioner Washington State Statewide Health Insurance Benefits Advisors (SHIBA) https://www.insurance.wa.gov/insurance-resources/medicare	1-800-562-6900 TTY: 1-360-586-0241
West Virginia	West Virginia State Health Insurance Assistance Program (WV SHIP) West Virginia Bureau of Senior Services 1900 Kanawha Boulevard East Town Center Mall, 3rd Level Charleston, WV 25305 https://www.wvship.org	1-877-987-4463 304-558-3317
Wisconsin	State Health Insurance Assistance Program (SHIP) https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	1-800-242-1060

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State Health Insurance Assistance Programs (SHIPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Wyoming	Wyoming State Health Insurance Information Program (WSHIIP) http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	1-800-856-4398

APPENDIX 2 Medicaid Agencies

State Medicaid Offices
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

States	Address/Website	Phone
Alabama	Alabama Medicaid Agency 501 Dexter Avenue PO Box 6524 Montgomery, AL 36104 https://medicaid.alabama.gov	1-800-362-1504 or in state call 334-242-5000
Alaska	Alaska Department of Health and Social Services 3601 C Street, Suite 902- Anchorage, AK 99503 https://health.alaska.gov	1-800-780-9972 or in state call 907-465-3030
Arizona	Arizona Health Care Cost Containment 801 East Jefferson Street Phoenix, AZ 85034 https://www.azahcccs.gov	800-523-0231 or in state call 602-417-4000 Toll Free: 800- 654-8713-
Arkansas	Arkansas Department of Human Services Donaghey Plaza South P.O. Box 1437 Slot S401 Little Rock, AR 72203 https://humanservices.arkansas.gov	800-482-5431 or in state call 501-682-8233
California	California Department of Health Care Services (DHCS) Medi-Cal Program https://www.dhcs.ca.gov/medi-cal	1-800-541-5555
Colorado	Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 https://hcpf.colorado.gov	1-800-221-3943 or in state call 303-866-2993 1-800-221-3943 State Relay: 711
Connecticut	Connecticut Department of Social Services (DSS)HUSKY C HUSKY Health Programs 55 Farmington Avenue Hartford, CT 06105 https://portal.ct.gov/DSS	1-855-626-6632
Delaware	Delaware Health and Social 1901 North DuPont Highway, Lewis Building P.O. Box 906 New Castle, DE 19720 https://dhss.delaware.gov/dhss	1-800-372-2022 or in state call 302-255-9500
District of Columbia	DC Department of Health Care Finance (DHCF) 441 4th Street NW, Suite 900S Washington, DC 20001 https://dhcf.dc.gov/service/medicaid	Local: 1-202- 442-5955

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States	**Address/Website**	**Phone**
Florida	Florida Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL. 32308 https://ahca.myflorida.com	1-850-300-4323 1-877-711-3662
Georgia	Georgia Department of Community Health 2 Peachtree Street NW Atlanta, GA 30303 https://dch.georgia.gov/	1-404-656-4507
Guam	Division of Senior Citizens (DPHSS) https://dphss.guam.gov	1-671-735-7415
Hawaii	Department of Human Services PO Box 339 Honolulu, HI 96809 https://medquest.hawaii.gov/	1-800-316-8005 or in state call 808-524-3370
Idaho	Idaho Department of Health and Welfare 450 West State Street Boise, ID 83720 https://healthandwelfare.idaho.gov	1-877-456-1233
Illinois	Illinois Department of Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763 https://hfs.illinois.gov	800-843-6154 or call 800-226-0768
Indiana	Indiana Family and Social Services Administration FSSA Document Center 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46207 https://www.in.gov/fssa/ompp	1-800-403-0864 or in state call 317-233-4454
Iowa	Iowa Medicaid Enterprise Department of Human Services Hoover State Office Building 5th Floor Des Moines, IA 50319 https://hhs.iowa.gov	1-800-338-8366 or in state call 515-256-4606
Kansas	Kansas Department of Health and Environment 1000 SW Jackson Street Topeka, KS 66612 https://www.kdhe.ks.gov	785-296-1500
Kentucky	Kentucky Cabinet for Health Services PO Box 2100 Frankfort, KY 40602 https://www.chfs.ky.gov/	800-635-2570 or in state call 502-564-4321
Louisiana	Louisiana Department of Health (LDH) Louisiana Medicaid 628 North 4th Street Baton Rouge, LA 70802 https://ldh.la.gov/healthy-louisiana	1-888-342-6207

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State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
States	**Address/Website**	**Phone**
Maine	Maine Department of Health and Human Services 109 Capitol St. 11 State House Station Augusta, ME 04333 https://www.maine.gov/dhhs	207-287-3707
Maryland	Maryland Department of Health– Medicaid 201 West Preston Street Baltimore, MD 21201 https://health.maryland.gov/mmcp	877-463-3464
Massachusetts	Massachusetts Office of Health and Human Services MassHealth 100 Hancock St. 1st Floor Quincy, MA 02171- https://www.mass.gov/masshealth	1-800-841-2900
Michigan	Michigan Department of Health and Human Services (MDHHS) Healthy Michigan Plan/MI Bridges https://www.michigan.gov/mdhhs	800-642-3195 or in state call 517-373-3740
Minnesota	Minnesota Department OF Human Services 444 Lafayette Road North St. Paul, MN 55155 https://mn.gov/dhs/	651-431-2700 or 800-366-5411
Mississippi	Mississippi Division of Medicaid 550 High Street, Suite 1000 Jackson, MS 39201 https://www.medicaid.ms.gov	1-800-421-2408
Missouri	Missouri Department of Social Services/ PO Box 2320 PO Box 1527 Jefferson City, MO 65102 https://mydss.mo.gov	800-735-2466 or in state call 573-751-3221
Montana	Montana Department of Public Health and Human Services 1400 Broadway PO Box 8005 Helena, MT 59604- https://dphhs.mt.gov/	800-362-8312
Nebraska	Nebraska Department of Health and Human Services System 301 Centennial Mall South Lincoln, NE 68509 https://dhhs.ne.gov	1-855-632-7633 or in state call 402-471-3121
Nevada	Nevada Department of Health and Human Services 1100 East William Street Suite 101 Carson City, NV 89701 https://dwss.nv.gov	1-800-992-0900 or in state call 775-684-0615

Appendix 2: Medicaid Agencies

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
States	**Address/Website**	**Phone**
New Hampshire	New Hampshire Department of Health & Human Services 129 Pleasant Street Concord, NH 03301 https://nheasy.nh.gov	1-844-275-3447 Option 8 TTY 1-800-735-2964
New Jersey	New Jersey Department of Human Services Aging and Disability Resource Connection NJ Medicaid P.O. Box 712 Quakerbridge Plaza Building 7 Trenton, NJ 08625 https://www.adrcnj.org	1-800-792-9745 1-800-701-0710
New Mexico	New Mexico Health Care Authority (HCA) New Mexico Medicaid Managed Care Program - Turquoise Care https://www.hca.nm.gov	1-800-283-4465
New York	New York State Department of Health Medicaid https://www.health.ny.gov/health_care/medicaid	1-800-541-2831
North Carolina	North Carolina Department of Health and Human Services 2501 Mail Service Center Raleigh, NC 27699-2501 https://medicaid.ncdhhs.gov	1-888-245-0179 or in state call 919-855-4100
North Dakota	North Dakota Department of Human Services Resources 600 East Boulevard Avenue, Department 325 Bismarck, ND 58505-0250 https://www.hhs.nd.gov	1-800-472-2622 or call in state call 701-328-2310
Ohio	Ohio Department of Job and Family Services 50 West Town Street, Suite 400 Columbus, Ohio 43215 https://medicaid.ohio.gov	1-800-324-8680
Oklahoma	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 https://oklahoma.gov/ohca.html	1-800-987-7767 Local: 1-405-522-6205
Oregon	Oregon Department of Human Services 500 Summer Street, NE, E15 Salem, OR 97301 https://www.oregon.gov/odhs	800-699-9075
Pennsylvania	Pennsylvania Medicare Education and Decision Insight, PA MEDI https://www.pa.gov/agencies/aging/aging-programs-andservices/pa-medi-medicare-counseling	1-800-783-7067

Appendix 2: Medicaid Agencies

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
States	**Address/Website**	**Phone**
Puerto Rico	Programa Medicaid Department de Salud P.O. Box 70184 San Juan, PR 00936-8184 https://www.medicaid.pr.gov/Medicaid	787-641-4224
Rhode Island	Rhode Island, Department of Human Services (DHS) Health Source Rhode Island 3 West Road Cranston, RI 02920 https://staycovered.ri.gov	1-855-697-4347
South Carolina	South Carolina Department of Health and Human Services Healthy Connections Medicaid P.O. Box 8206 Columbia, SC 29202-8206 https://www.scdhhs.gov	1-888-549-0820 TTY 1-888-842-3620
South Dakota	South Dakota Department of Social Services 700 Governors Dr. Pierre, SD 57501 https://dss.sd.gov/medicaid	1-800-597-1603 Local: 605-773-3165
Tennessee	Tennessee Division of TennCare 3100 Great Circle Rd Nashville, TN 37243 https://www.tn.gov/tenncare	1-800-342-3145
Texas	Texas Health and Human Services https://hhs.texas.gov/services/health/medicaid-chip	800-252-9240
Utah	Utah Department of Health Medicaid & Human Services Integrated Health 288 North 1460 West Salt Lake City, UT 84116 https://medicaid.utah.gov/contact	1-866-435-7414
U.S. Virgin Islands	Government of the U.S. Virgin Islands Department of Human Services **St. Thomas**-VI Medicaid Program Department of Human Services Knud Hansen Complex 1303 Hospital Ground, Bldg. A St. Thomas, Virgin Islands 00802 **St. Croix-**VI Medicaid Program Department of Human Services 3011 Golden Rock, Christiansted St Croix, Virgin Islands, 00820 https://www.vimmis.com	St. Thomas/ St. John District: 340-774-0930 St. Croix District: 340-772-7100
Vermont	State of Vermont Agency of Human Services 280 State Drive, Center Building Waterbury, VT 05671 https://humanservices.vermont.gov	802-241-0440

Appendix 2: Medicaid Agencies

State Medicaid Offices TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
States	**Address/Website**	**Phone**
Virginia	Virginia Department of Medical Assistance Services 600 East Broad Street Richmond, VA 23219 https://www.dmas.virginia.gov/	804-786-7933
Washington	Washington State Health Care Authority Apple Health – Medicare Savings Programs (MSPs) Apple Health Classic Medicaid Coverage https://www.hca.wa.gov/free-or-low-cost -health-care	1-800-562-3022 TTY/TDD: 1-855-627-9604
West Virginia	West Virginia Department of Human Services Bureau of Medical Services 350 Capitol Street, Room 251 Charleston, WV25301 https://bms.wv.gov/	304-558-1700
Wisconsin	Wisconsin Department of Health Services 201 E. Washington Ave. Madison, WI 53703 https://www.dhs.wisconsin.gov/	1-800-362-3002 in state call 608-266-1865 TTY: 711
Wyoming	Wyoming Department of Health 401 Hathaway Building Cheyenne, WY 82002 https://health.wyo.gov/	1-866-571-0944 in state call 307-777-7656

APPENDIX 3 AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

State	Address/Website	Phone
Alabama	Alabama AIDS Drug Assistance Program HIV/AIDS Division Alabama Department of Public Health The RSA Tower 201 Monroe St., Suite 1400 Montgomery, AL 36104 https://www.alabamapublichealth.gov/hiv/adap.html	1-866-574-9964
Alaska	Alaskan AIDS Assistance Association 1057 W. Fireweed Ln., Suite 102 Anchorage, AK 99503 https://www.alaskanaids.org/client-services/aids-drug-assistance-program-adap	1-800-478-2437
Arizona	Arizona Department of Health Services 150 N. 18th Ave., Phoenix, AZ 85007 https://azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php	1-800-334-1540 1-602-364-3610
Arkansas	Arkansas Department of Health Infectious Disease Branch 4815 W. Markham St., Slot 33 Little Rock, AR 72205 https://healthy.arkansas.gov/programs-services/topics/ryan-white-program	1-501-661-2408
California	California Department of Public Health Center for Infectious Diseases Office of AIDS MS 0500, P.O. Box 997377 Sacramento, CA 95899-7377 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx	1-844-421-7050 ADAP CALL CENTER
Colorado	Colorado Department of Public Health Environment Care and Treatment Program ADAP-3800 4300 Cherry Creek Dr. South Denver, CO 80246 https://colorado.gov/PACIFIC/CDPHE/state-drug-assistance-program	1-303-692-2000
Connecticut	Connecticut Department of Public Health 410 Capitol Ave. Hartford, CT 06134 https://ctdph.primetherapeutics.com/	1-800-424-3310
Delaware	Division of Public Health Thomas Collins Building 540 S. DuPont Highway Dover, DE 19901 https://ramsellcorp.com/medical_professionals/de.aspx	Local: 1-302-744-1050 Customer Service: 1-888-311-7632

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
District of Columbia	District of Columbia Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration, AIDS Drugs Assistance Program 899 North Capitol St, NE Washington, DC 20002 https://dchealth.dc.gov/DC-ADAP	202-671-4900 or 202-671-4815 (DC ADAP Hotline)
Florida	Florida Department of Health HIV/AIDS Section AIDS Drug Assistance Program 4052 Bald Cypress Way Tallahassee, FL 32399 https://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-844-381-2327
Georgia	Georgia Department of Public Health, Health Protection, Office of HIV/AIDS 2 Peachtree St. NW Atlanta, GA 30303 https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805
Hawaii	Hawaii Department of Health Harm Reduction Services Branch 3627 Kilauea Ave., #306 Honolulu, HI 96816 https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/	1-808-733-9360 1-808-733-9361
Idaho	Idaho Ryan White Part B Program 450 West State St. P.O. Box 83720 Boise, ID 83720 https://healthandwelfare.idaho.gov/Health-wellness/diseases-conditions/ human-immunodeficiency-virus-hiv	1-208-334-5612 HIV Prevention: 1-208-616-2755 RyanWhite/ADAP: 1-208-985-3019
Illinois	Illinois Medication Assistance Program 525 W. Jefferson St., 1st Floor Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	1-800-825-3518
Indiana	Indiana State Department of Health, HIV/STD Viral Hepatitis Division 2 North Meridian St., Suite 6C Indianapolis, IN 46204 https://www.in.gov/health/hiv-std-viral-hepititis/hiv-services/#programs	1-866-588-4948
Iowa	Iowa Health and Human Services Bureau of HIV, STI, and Hepatitis 321 East 12th St. Des Moines, IA 50319-0075 https://hhs.iowa.gov/hiv-sti-and-hepatitis/hivaids-program	1-515-204-3746

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Kansas	Kansas Department of Health & Environment 1000 South West Jackson, Suite 210 Topeka, KS 66612 https://www.kdhe.ks.gov/355/The-Ryan-White-Part-B-Program	1-785-296-6174
Kentucky	Kentucky Department for Public Health Cabinet for Health and Family Services HIV/AIDS Branch 275 East Main St., HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-502-564-6539 1-800-420-7431
Louisiana	Louisiana Office of Public Health Louisiana Health Access Program 1450 Poydras St., Suite 2136 New Orleans, LA 70112 https://www.lahap.org/	1-504-568-7474
Maryland	Maryland AIDS Drug Assistance Program 1223 W Pratt St Baltimore, MD 21223 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP	1-410-767-6535
Maine	Maine Center for Disease Control and Prevention ADAP 40 State House Station Augusta, ME 04330 https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml	1-207-287-3747
Massachusetts	Community Resource Initiative Attn: Community research Initiative of New England/HDAP The Schrafft's City Center 529 Main St., Suite 301 Boston, MA 02129 https://crihealth.org/drug-assistance/hdap/	1-800-228-2714 617-502-1700 option 1
Michigan	HIV Care Section Division of HIV/STI Programs, Client and Partner Services Bureau of HIV and STI Programs Michigan Department P.O. BOX 30727 Lansing, MI 48913 https://www.michigan.gov/en/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program	1-888-826-6565
Minnesota	HIV/AIDS Programs Minnesota Department of Human Services P.O. Box 64972 St. Paul, MN 55164 https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp	1-800-657-3761

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Mississippi	Mississippi State Department of Health Office of STD/HIV Care and Treatment Division P.O. BOX 1700 Jackson, MS 39215 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html	1-888-343-7373
Missouri	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102 https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	1-888-252-8045
Montana	Montana Ryan White HIV Treatment Program 1400 Broadway Cogswell Bldg. Room C-211 1400 Broadway Helena, MT 59620 https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog	1-406-444-3565 1-406-444-5622
Nebraska	Nebraska AIDS Drug Assistance Program P.O. Box 95026 Lincoln, NE 68509 https://dhhs.ne.gov/Pages/HIV-Care.aspx	1-402-471-2101
Nevada	Office of HIV2290 S. Jones Blvd, Suite 110 Las Vegas, NV 89146 https://endhivnevada.org/ryan-white-care/	1-702-486-0768
New Hampshire	DHHS-NH CARE Program 29 Hazen Dr. Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-aids	1-603-271-4502 800-852-3345
New Jersey	New Jersey ADDP Office P.O. Box 360 Trenton, NJ 08625 https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml	1-877-613-4533
New Mexico	New Mexico Department of Health HIV Services Program 1190 St. Francis Dr., Suite S-1200 Santa Fe, NM 87502 https://nmhealth.org/about/phd/idb/hats/	1-505-476-3628
New York	HIV Uninsured Care Programs, Empire Station P.O. Box 2052 Albany, NY 12220 https://www.health.ny.gov/diseases/aids/general/resources/adap/	1-800-542-2437 1-844-682-4058

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
North Carolina	N.C. Dept. of Health and Human Services, Epidemiology Section Communicable Disease Branch 1907 Mail Service Center Raleigh, NC 27699 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-877-466-2232 919-733-9161
North Dakota	North Dakota Department of Health Division of Disease Control 2635 E. Main Avenue Bismarck, ND 58506-5520 https://www.ndhealth.gov/hiv/RyanWhite/	1-800-472-2180 701-328-2378
Ohio	Ohio AIDS Drug Assistance Program (ADAP), HIV Client Services, Ohio Department of Health 246 North High St. Columbus, OH 43215 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/	1-800-777-4775
Oklahoma	HIV/STD Services Division, Oklahoma State Department of Health 1000 N.E. Tenth St. Mail Drop 0308 Oklahoma City, OK 73117-1299 https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/prevention-and-preparedness/sexual-health-harm-reduction/provider-info/training-material/hiv-hdapbrochure14.pdf	1-405-271-4636
Oregon	CAREAssist Program 800 NE Oregon St., Suite 1105 Portland, OR 97232 https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/index.aspx	1-971-673-0144
Pennsylvania	Pennsylvania Department of Health Special Pharmaceutical Benefits Program 625 Forster St., H & W Bldg., Rm 611 Harrisburg, PA 17120 https://www.pa.gov/agencies/health/diseases-conditions/infectious-disease/hiv/special-pharmaceutical-benefits.html	1-800-922-9384
Rhode Island	Executive Office of Health and Human Services Office of HIV/AIDS Virks Building 3 West Rd. Suite 227 Cranston, RI 02920 https://www.eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	1-401-462-3295

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
South Carolina	South Carolina Drug Assistance Program DHEC Constituent Services 2600 Bull Street Columbia, SC 29211 https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	1-800-856-9954 HIV/STD Hotline: 1-800-322-2437
South Dakota	South Dakota Department of Health Ryan White Part B CARE Program 615 East 4th St. Pierre, SD 57501 https://doh.sd.gov/topics/disease-prevention-services/hivaids/ryan-white-part-b-program/	1-800-592-1861 605-773-3737
Tennessee	Tennessee Department of Health, HIV/STD Program, Ryan White Part B Services 710 James Robertson Parkway 4th Floor Andrew Johnson Tower Nashville, TN 37243 https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b.html	1-800-525-2437 615-741-7500
Texas	Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O. BOX 149347 Austin, TX 78714 https://www.dshs.texas.gov/hivstd/meds/	1-800-255-1090 737-255-4300
Utah	Utah Department of Health, Bureau of Epidemiology 288 North 1460 West Box 142104 Salt Lake City, UT 84114 https://epi.utah.gov/ryan-white	1-801-538-6191
Vermont	Vermont Department of Health, Vermont Medication Assistance Program(VMAP) 108 Cherry St., P.O. Box 70 Burlington, VT 05402 https://www.healthvermont.gov/immunizations-infectious-disease/hiv/care	1-802-951-4005 1-802-863-7314
Virginia	Virginia Department of Health, HCS Unit 1st Floor, James Madison Building 109 Governor St. Richmond, VA 23219 https://www.vdh.virginia.gov/disease-prevention/vamap/	1-855-362-0658
Washington	Client Services P.O. Box 47841 Olympia, WA 98504 The Early Intervention Program (EIP) Washington State's AIDS Drug Assistance Program (ADAP) https://doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/early-intervention-program	1-877-376-9316 (in Washington State) 360-236-3426

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

AIDS Drug Assistance Programs (ADAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address/Website**	**Phone**
Washington, DC	District of Columbia Department of health, HIV/AIDS, Hepatitis, STD, and TB Administration, AIDS Drugs Assistance Program 899 North Capitol St. NE Washington, DC 20002 https://dchealth.dc.gov/Pharmacy_Benefits	202-671-4900 DC ADAP Hotline 202-671-4815
West Virginia	West Virginia Office of Epidemiology & Prevention Services Jay Adams, HIV Care Coordinator P.O. Box 6360 Wheeling, WV 26003 https://oeps.wv.gov/rwp/pages/default.aspx	1-304-232-6822
Wisconsin	Department of Health Services Attn: ADAPP.O. Box 2659 Madison, WI 53701 https://www.dhs.wisconsin.gov/hiv/hdap.htm	1-800-991-5532 1-608-261-6952 1-608-267-6875
Wyoming	Wyoming Department of Health 401 Hathaway Building Cheyenne, WY 82002	1-307-777-7656 1-866-571-0944
American Samoa	Department of Public Health LBJ Tropical Medical Center P.O. Box F Pago Pago, AS 96799 https://nastad.org/sites/default/files/2024-06/NASTAD%20Membership%20Directory%20as%20of%206_24_2024.pdf	011-684-633-1433
Federated Sates of Micronesia	Federated States of Micronesia, Department of Health Services, FSM National HIV/AIDS Program Mogithin Building Palikir Sta P.O. Box PS-70 Palikir Pohnpei, FM 96941 https://www.fsmgov.org	011-691-320-2619
Guam	Department of Public Health and Social Services, Bureau of Communicable Disease of Control Ryan White HIV/AIDS Office 520 West Santa Monica Avenue Dededo, GU 96929 http://dphss.guam.gov/ryan-white-hiv-aids-program/	671-735-3603
Marshall Islands	Majuro, MH	011-692-329-4031
Northern Mariana Islands	CNMI Department of Public Health P.O. Box 500409 Saipan, MP 96950 https://www.chcc.health/	1-670-664-4050
Palau	Ministry of Public Health, Communicable Disease Unit P.O. Box 6027 Koror, PW 96940 https://www.palaugov.pw/	011-680-488-1360

Appendix 3: AIDS Drug Assistance Programs (ADAPs)

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State	**Address/Website**	**Phone**
Puerto Rico	Departamento de Salud, OCASet, Programa Ryan White PartB P.O. Box 70184 San Juan, PR 00936-8184 https://www.salud.pr.gov/CMS/DOWNLOAD/6886	1-787-765-2929 Ext. 5106-5137
Virgin Islands	John Moorehead Complex (Old Hospital) Communicable Diseases Clinic, Building 1 St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases/	1-340-774-9000

APPENDIX 4 State Pharmaceutical Assistance Programs (SPAPs)

State Pharmaceutical Assistance Programs (SPAPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

State	Address / Website	Phone
Alabama	SenioRx RSA Tower 201 Monroe Street Suite 350 Montgomery, AL 36104 https://alabamaageline.gov/seniorx/	334-242-5743 or 1-800-243-5463
Alaska	Senior Benefits Program DPA: Services https://health.alaska.gov/en/services/division-of-public-assistance-dpa-services-senior-benfits-program	1-800-478-7778
Arizona	Arizona Rx Card Arizona Rx Card is a free statewide discount prescription assistance program. The program was launched to help uninsured and underinsured residents afford their prescriptions. Online only. https://arizonaxcard.com	1-602-604-0640
California	California Department of Health Care Services Medi-Cal Rx https://medi-calrx.dhcs.ca.gov	1-800-977-2273
Colorado	State Drug Assistance Program (SDAP) 4300 Cherry Creek Dr South Denver, CO 80246	303-692-2000
Connecticut	Connecticut Social Services Drug Assistance Program(CADAP) 55 Farmington Ave. Hartford, CT 06105 https://portal.ct.gov/dss	1-855-789-2428
District of Columbia	DC Health – Pharmacy Benefits Program (formerly known as DC ADAP) 2201 Shannon Place SE Washington, DC 20020 https://dchealth.dc.gov/pharmacy_Benefits_Program	1-202-671-4815
Indiana	Indiana Family & Social Services Administration HooseirRx 402 W. Washington St., Room W374, MS07 Indianapolis, IN 46204 https://www.in.gov/medicaid/members/member-programs/hoosierrx	1-866-267-4679
Kentucky	Kentucky Prescription Assistance Program (KPAP)	1-800-633-8100

Appendix 4: State Pharmaceutical Assistance Programs (SPAPs)

State Pharmaceutical Assistance Programs (SPAPs) TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.		
State	**Address / Website**	**Phone**
	https://www.chfs.ky.gov/agencies/dph/dpqi/hcab/pages/kpap.aspx	
Maine	Maine State Pharmacy Assistance Programs (SPAP) Office of MaineCare Services 242 State St August, ME 04333 https://www.main.gov/kkkkdhhs/oms	1-866-796-2463
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP) SeniorRx Prescription Drug Assistance Programhttps://marylandspdap.com	1-800-551-5995
Massachusetts	MassHealth Executive Office of Aging & Independence(AGE) Services Medicare Savings Programs (MSPs) https://www.prescriptonadvantagema.org	1-800-841-2900
Michigan	Michigan Department of Health & Human Services Limited and disease-specific assistance programs https://www.michigan.gov/mdhhs	1-888-826-6565
Missouri	Missouri Rx Plan (MORx) https://mydss.mo.gov/mhd	1-573-751-6963
Montana	Montana Department of Public Health & Human Services Big Sky Rx Program https://dphhs.mt.gov/SLTC/aging/bigsky	1-866-369-1233
Nevada	Nevada – Ramsell NV Medication Assistant Program (NMAP) https://ramsellcorp.com/pharmacies/nv.aspxhttps://adsd.nv.gov	1-888-311-7632
New Jersey	Pharmaceutical Assistance to the Aged and Disabled (PAAD) https://www.nj.gov/humanservices/doas/services/l-p/paad	1-800-792-9745
New Mexico	The New Mexico Prescription Drug Assistance Program https:/www.aging.nm.gov/consumer-and-elder-rights/prescription-drug-assistance	1-800-432-2080
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) Program https://www.health.ny.gov/health_care/epic	1-800-332-3742
North Carolina	NC Department of Health and Human Services North Carolina Medication Assistance Program NC MEDAssist https://www.ncdhhs.gov	1-866-331-1348

State Pharmaceutical Assistance Programs (SPAPs)
TTY numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking. If there is no TTY number indicated, dial 711.

State	Address / Website	Phone
Oklahoma	RX for Oklahoma Prescription Assistance RX4OKLA.com	1-877-794-6552
Oregon	Oregon Health Authority Oregon Prescription Drug Program - ArrayRx https://www.oregon.gov/oha/hpa/dsi-opdp	1-800-913-4146
Pennsylvania	Pennsylvania Department of Aging Pennsylvania's Prescription Assistance Programs PACE and PACENET https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program	1-800-225-7223
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elders (RIPAE) https://oha.ri.gov/resources/health-insurance-health-care-cost-assistance/drug-cost-asistance	1-401-462-0560
Texas	Texas Health and Human Services State Pharmacy Assistance Program (SPAP) – Ramsell Corporation https://www.dshs.texas.gov/hivstd/meds/spap	1-888-311-7632
Vermont	Department of Vermont Health Access - VPharm Green Mountain Care https://dvha.vermont.gov/members/prescription-assistance	1-800-250-8427
Virginia	Viginia Department of Health - Virginia Medication Assistance Program (VA MAP) https://www.vdh.virginia.gov/disease-prevention	1-855-362-0658
Wisconsin	Wisconsin Department of Health Services - SeniorCare: Prescription Drug Assistance Program https://www.dhs.wisconsin.gov/seniorcare	1-800-657-2038

Notice of Availability of Language Assistance and Auxiliary Aids and Services

MEDICAL MUTUAL®

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PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-382-5729 (TTY: 711) o makipag-usap sa iyong provider.

Romanian

ATENȚIE: Dacă vorbiți Română, aveți la dispoziție servicii de asistență lingvistică gratuite. De asemenea, sunt disponibile gratuit materiale și servicii auxiliare adecvate pentru furnizarea de informații în formate accesibile. Sunați la 1-800-382-5729 (TTY: 711) sau contactați-vă furnizorul.

Japanese

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-382-5729（TTY:711）までお電話ください。または、ご利用の事業者にご相談ください。

Order Number: Z8188-MCA R8.25
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Dutch

LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-382-5729 (TTY: 711) of spreek met je provider.

Pennsylvania Dutch

WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-800-382-5729 (TTY: 711) uff odder schwetz mit dei Provider.

Ukrainian

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-382-5729 (TTY: 711) або зверніться до свого постачальника.

Navajo

BAA'ÁKONÍNÍZIN: Diné bizaad bíyáti' nílt'įį', t'áá jíík'ehgo saad bee áká anilyeedígíí t'áá hóló. T'áá jíík'ehgo áká anilyeedígíí dóó bee haz'ánígíí t'áá hóló, t'áá íiyisí bee t'áá ájík'ehgo. 1-800-382-5729 (TTY: 711) bich'į' hodíilnih dóó provider ni'doolníił.

Notice of Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Medical Mutual of Ohio complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Medical Mutual of Ohio does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Medical Mutual of Ohio:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at CivilRightsCoordinator@MedMutual.com.

If you believe that Medical Mutual of Ohio has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

100 American Road
Cleveland, OH 44144

Call: 1-800-382-5729 (TTY: 711)
Email: CivilRightsCoordinator@MedMutual.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, our Civil Rights Coordinator (who is also our Section 1557 Coordinator) is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

- Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
- This notice is available at Medical Mutual's website: www.MedMutual.com

Questions about your benefits or other inquiries about your health insurance should be directed to Medical Mutual's Customer Care Department at 1-800-382-5729.

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

MedMutual Advantage PPO Plan Customer Care

Method	Customer Care - Contact Information
Call	1-800-801-4823 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays). Our automated telephone system is available 24 hours a day, seven days a week for self-service options. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Customer Care Specialists are available to answer your call directly 8 a.m. to 8 p.m. seven days a week from October 1 through March 31 (except Thanksgiving and Christmas), and 8 a.m. to 8 p.m. Monday through Friday from April 1 through September 30 (except holidays).
Write	Medical Mutual Attn: Customer Care P.O. Box 94563 Cleveland, OH 44101-4563
Website	MedMutual.com/MAgroup

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. See Appendix 1 to find the SHIP for your state.

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