January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of MCS Classicare Platino Total (HMO D-SNP)

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

For questions about this document, please contact our Call Center at 1-866-627-8183 (Toll Free), 787-620-2530 (Metro Area). (TTY users should call 1-866-627-8182). Hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. This call is free.

This plan, MCS Classicare Platino Total (HMO D-SNP), is offered by MCS Advantage, Inc. (MCS Classicare). (When this *Evidence of Coverage* says "we," "us," or "our," it means MCS Advantage, Inc. (MCS Classicare). When it says "plan" or "our plan," it means MCS Classicare Platino Total (HMO D-SNP).)

This document is available for free in Spanish.

This information is available in different formats including, large print, braille, and audio CD. Please call our Call Center at the numbers listed above if you need plan information in another format or language.

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

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

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

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

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

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in MCS Classicare Platino Total (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, MCS Classicare Platino Total (HMO D-SNP). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

MCS Classicare Platino Total (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. MCS Classicare Platino Total (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid with your Medicare Part A and B cost sharing (copayments and coinsurance) you may pay nothing for your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services and prescription drugs that are not usually covered under Medicare. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. MCS Classicare Platino Total (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

MCS Classicare Platino Total (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare.The plan also has a contract with the Puerto Rico Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

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

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

This *Evidence of Coverage* document tells you how to get your Medicare and Medicaid medical care and

prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of MCS Classicare Platino Total (HMO D-SNP).

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

If you are confused or concerned or just have a question, please contact our Call Center.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how MCS Classicare Platino Total (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in MCS Classicare Platino Total (HMO D-SNP) between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of MCS Classicare Platino Total (HMO D-SNP) after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) and Medicaid (Puerto Rico Health Insurance Administration) must approve MCS Classicare Platino Total (HMO D-SNP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan. Each year your plan is also approved by the Puerto Rico Health Insurance Administration to offer its Medicaid benefits.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medicaid.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within six (6)-month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

Section 2.3 Here is the plan service area for MCS Classicare Platino Total (HMO D-SNP)

MCS Classicare Platino Total (HMO D-SNP) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these municipalities in Puerto Rico: Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Añasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamón, Cabo Rojo, Caguas, Camuy, Canóvanas, Carolina, Cataño, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerío, Corozal, Culebra, Dorado, Fajardo, Florida, Guánica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Lares, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Peñuelas, Ponce, Quebradillas, Rincón, Río Grande, Sabana Grande, Salinas, San Germán, San Juan, San Lorenzo, San Sebastián, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa, and Yauco.

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

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

Section 2.4 U.S. Citizen or Lawful Presence

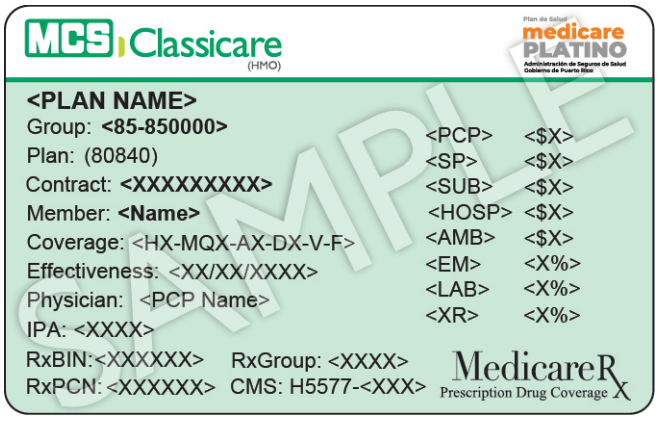
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States.

Medicare (the Centers for Medicare & Medicaid Services) will notify MCS Classicare Platino Total (HMO D-SNP) if you are not eligible to remain a member on this basis. MCS Classicare Platino Total (HMO D-SNP) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

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

Section 3.2 Providers and Pharmacies Directory

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain

services in-network), out-of-area dialysis services, and cases in which MCS Classicare Platino Total (HMO D-SNP) authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at www.mcsclassicare.com.

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

Section 3.3 Providers and Pharmacies Directory

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

If you don't have the *Providers and Pharmacies Directory*, you can get a copy from our Call Center. You can also find this information on our website at www.mcsclassicare.com.

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

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

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

We will provide you a copy of the "Drug List." To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.mcsclassicare.com) or call our Call Center.

SECTION 4 Your monthly costs for MCS Classicare Platino Total (HMO D-SNP)

Your costs may include the following:

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

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for MCS Classicare Platino Total (HMO D-SNP).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most MCS Classicare Platino Total (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

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

Section 4.3 Part D late enrollment penalty

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

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

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

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you

were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $34.70, which equals $4.86. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

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

Section 4.4 Income Related Monthly Adjustment Amount

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

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

extra amount you will be disenrolled from the plan and lose prescription drug coverage.

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

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

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

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

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

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

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider (PCP) and Independent Physician Association (IPA).

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

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

If any of this information changes, please let us know by calling our Call Center.

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

SECTION 7 How other insurance works with our plan

Other Insurance

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

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

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

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

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

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

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 MCS Classicare Platino Total (HMO D-SNP) contacts (how to contact us, including how to reach our Call Center)

How to contact our plan's Call Center

For assistance with claims, billing, or member card questions, please call or write to our MCS Classicare Platino Total (HMO D-SNP) Call Center. We will be happy to help you.

Method	Call Center – Contact Information
CALL	1-866-627-8183 Calls to this number are free. 787-620-2530 (Metro Area) Calls to this number are *not* free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Our Call Center also has free language interpreter services available for non-English speakers.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-1337
WRITE	MCS Advantage, Inc. Call Center PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical

care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-1336
WRITE	MCS Advantage, Inc. Clinical Affairs Department PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Medical Care – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-7765
WRITE	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
WEBSITE	www.mcsclassicare.com

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

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

Method	Complaints about Medical Care – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-7765
WRITE	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
MEDICARE WEBSITE	You can submit a complaint about MCS Classicare Platino Total (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	1-866-763-9097
WRITE	MCS Advantage, Inc. Pharmacy Department PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	1-866-763-9097
WRITE	MCS Advantage, Inc. Pharmacy Department PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints about Part D prescription drugs – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-7765
WRITE	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
MEDICARE WEBSITE	You can submit a complaint about MCS Classicare Platino Total (HMO D-SNP) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information
CALL	787-620-2530 (Metro Area) Calls to this number are *not* free. 1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-1337
WRITE	MCS Advantage, Inc. Claims Department PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about MCS Classicare Platino Total (HMO D-SNP): • **Tell Medicare about your complaint:** You can submit a complaint about MCS Classicare Platino Total (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Puerto Rico, the SHIP is called State Health Insurance Assistance Program.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org/. Click on SHIP LOCATOR in middle of page.
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	State Health Insurance Assistance Program (Puerto Rico SHIP) – Contact Information
CALL	1-877-725-4300 (Metro Area) 1-800-981-0056 (Mayagüez Area) 1-800-981-7735 (Ponce Area)
TTY	787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	State Health Insurance Assistance Program Puerto Rico Office of the Ombudsman for the Elderly PO BOX 191179 San Juan, PR 00919-1179 shippr@oppea.pr.gov
WEBSITE	https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Puerto Rico, the Quality Improvement Organization is called Livanta, LLC.

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

You should contact Livanta, LLC in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta, LLC (Puerto Rico's Quality Improvement Organization) – Contact Information
CALL	787-520-5743 1-866-815-5440 (toll free) 1-855-236-2423 (fax) Monday through Friday from 9:00 a.m. to 5:00 p.m. Saturday and Sunday from 11:00 a.m. to 3:00 p.m. 24-hour voice mail available.
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal

Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

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

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In Puerto Rico, plans that combine Medicaid and Medicare benefits are called Medicare Platino plans. MCS Classicare Platino Total (HMO D-SNP) is a dual eligible special needs plan under Medicare Platino. Because both Medicaid and Medicare benefits are integrated, you normally have low cost-sharing for services and prescription drugs, use only one membership card to access services, and do not need referrals for specialists within the same medical group, among other benefits that non-Platino plans do not have.

To have a Platino plan, you must be a dual - Medicaid and Medicare - eligible member: You must have Medicare Part A and Part B, and you must have Medicaid in Puerto Rico. Our plan must be approved by the Puerto Rico Health Insurance Administration (PRHIA), and by the Centers for Medicare and Medicaid Services (CMS).

If you lose Medicaid eligibility, you are no longer entitled to Platino benefits and can no longer be a member of our plan. You will be kept in our plan for six months, starting the month after we learn that you are no longer Medicaid certified. If you do not want to lose your Medicaid eligibility, you must call your Medicaid office immediately to request an appointment, to be re-certified so you don't lose your Platino benefits.

If you are not re-certified by Medicaid by the end of the six months, you will have a special enrollment period during which you can choose to have another MCS Classicare health plan, or a Medicare Advantage plan from another company. If you do not choose a plan, you will have only your Original Medicare coverage. In Original Medicare, you will need to get separate prescription drugs coverage (Medicare Part D); if you do not get Part D coverage during the special enrollment period, you may have to pay a late enrollment penalty in the future.

We will be in touch with you during the six-month grace period to help you understand the process if you lose Platino eligibility, and to help you understand the importance of keeping your Platino benefits.

If you have questions about the assistance you get from Medicaid, contact the Puerto Rico Department of Health's Medicaid Program.

Method	Puerto Rico Department of Health - Medicaid Program – Contact Information
CALL	787-641-4224 Monday through Friday from 8:00 a.m. to 6:00 p.m.
TTY/TDD	787-625-6955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Medicaid Program Puerto Rico Department of Health PO BOX 70184 San Juan, PR 00936-8184 prmedicaid@salud.pr.gov
WEBSITE	https://www.medicaid.pr.gov/

You can also contact the Puerto Rico Health Insurance Administration at 1-800-981-2737 or write to the following address: P.O. Box 195661 San Juan, P.R. 00919-5661.

The Puerto Rico Office of the Patient's Advocate helps people enrolled in Medicaid with service or billing

problems. They can help you file a grievance or appeal with our plan.

Method	Puerto Rico Office of the Patient's Advocate - Contact Information
CALL	787-977-0909 1-800-981-0031 Monday through Friday from 8:00 a.m to 4:30 p.m
TTY	787-710-7057 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Puerto Rico Office of the Patient's Advocate PO Box 11247 San Juan PR 00910-2347 info@opp.pr.gov
WEBSITE	https://www.opp.pr.gov

The Puerto Rico Office of the Ombudsman for the Elderly helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	Puerto Rico Office of the Ombudsman for the Elderly – Contact Information
CALL	787-721-6121 Metro Area 787-986-7105 Mayagüez Area 787-841-1180 Ponce Area
TTY	787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Puerto Rico Office of the Ombudsman for the Elderly PO BOX 191179 San Juan, PR 00919-1179
WEBSITE	www.oppea.pr.gov

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

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

Medicare's "Extra Help" Program

Most of our members qualify for and are already getting "Extra Help" from Medicare to pay for their prescription drug plan costs.

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the Health Insurance Assistance Program (HIAP) - Ryan White Part B / ADAP Program - Puerto Rico Department of Health.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 787-765-2929, exts. 5106, 5136, 5137, or 5149.

SECTION 8 How to contact the Railroad Retirement Board

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

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

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

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

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

CHAPTER 3:

Using the plan for your medical and other covered services

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

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

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

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing or only your share of the cost for covered services.
- **Covered services** include all the medical care, health care services, supplies equipment and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare and Medicaid health plan, MCS Classicare Platino Total (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. Please refer to the Medical Benefits Chart in Chapter 4, under the section titled "Benefits Covered by the Health Department's Medicaid Program".

MCS Classicare Platino Total (HMO D-SNP) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of

your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Before seeking care, contact the plan to know if the service requires coordination or preauthorization.In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

SECTION 2 Use providers in the plan's network to get your medical care and other services

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

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

When you become a member of our plan, you must choose a plan provider to be your primary care physician. A primary care physician (PCP) is a participating provider duly licensed to practice medicine in Puerto Rico, who provides evaluation, treatment, and coordination of medically necessary services for the patient. Each PCP belongs to a Primary Medical Group or IPA (Independent Practice Association). An IPA is an organization of independent doctors, or groups of primary doctors, that have contracted with us to offer covered medical services. The IPA is also responsible for providing you coordinated care services.

What types of providers may act as a PCP?

You may select your PCP among the following physicians:

- General Physician
- Family Practitioner
- Internal Medicine Physician
- Geriatrician (if you are 60 years of age or older)

Under certain conditions, other types of specialists can become your primary care physician. Contact the plan for details.

The role of a PCP in your plan

Your PCP is responsible for providing evaluation, treatment and coordination of medically necessary services for your health care. Your PCP determines the services that you need, follows up, and when necessary provides referrals to specialized services. Your PCP is also responsible for completing the Comprehensive Health Risk Assessment (CHRA) questionnaire. In this questionnaire your PCP details all your health-related issues, including the performed physical exam, complete assessment of your conditions, your medical history, prescription drugs review, preventive care, among others. This evaluation will help your PCP determine the treatment options adequate for you.

What is the role of the PCP in coordinating covered services?

Your PCP is responsible for coordinating the services needed for your healthcare. Your PCP will coordinate all your preventive care and determine when you will need specialized treatment. You will need a referral from your PCP to get treatment from most network specialists, although there are certain exceptions. See Section 2.2 for details.

What is the role of the PCP in making decisions about or obtaining prior authorization, if applicable?

Your PCP may also coordinate certain covered services for you. For some types of services, your PCP may

need to get approval in advance from our plan (this is called getting "prior authorization"). Your PCP, the specialist, or you may need to contact our Call Center in case you need a prior authorization. There are some services that must be coordinated through the plan, such as renal dialysis when traveling outside of Puerto Rico (see Section 2.2).

How do you choose your PCP?

You will use your *Providers and Pharmacies Directory* to choose your PCP when enrolling in our plan. The directory includes a list of available providers. Once you choose a PCP, the member identification card that you will receive will show their name.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. Changing your PCP will not affect the services you receive from specialists and other allied health professionals you may use.

To change your PCP, call our Call Center at the telephone number mentioned in the back cover of this booklet. When you call, make sure to tell our Call Center representative if you are seeing specialists or getting other covered services that need your PCP's approval. Our Call Center representative will make sure that you can continue with the specialty care and other services you have been getting when changing your PCP. Your record will be updated and the change will be effective on the 1st day of the following month. In certain cases, you can request us to change your PCP in an expedited way. You may also request the change at any of our service centers.

When a PCP you are seeing leaves our network, you must choose another PCP from the participating providers network. If your PCP leaves our plan, we will let you know and help you choose another PCP so that you can keep getting covered services.

Care in a Transition Period: If the contract of your provider is terminated or cancelled, the plan will notify you within 30 calendar days before the termination date. You may continue receiving benefits from the same provider, during a 90 day transition period, beginning on the termination date or the date the provider cancelled their contract. Certain exceptions may apply.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are covered services that are not emergency services, provided when the

network providers are temporarily unavailable or inaccessible, or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call our Call Center before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- If your PCP sends you to any specialist that is within or contracted with your Primary Medical Group (the specialist must send your PCP a report about services rendered to you). However, services from specialists outside of your primary care group or IPA, require referral from your PCP. Read ahead for the exceptions.
- Services rendered during a hospitalization and transition from inpatient to other institutions (these institutions may include home health agencies, hospitals and skilled nursing facilities)
- A prescription is written by the specialist treating you
    - Bioequivalent prescription drugs are mandatory
- Pathological labs and most of the conventional radiological services (services without contrast)
- Visits and services rendered at OB/GYN or urologist offices
- If you are diagnosed with one of the following special or chronic conditions, you may access the provider treating and offering related services without your PCP's referral. Please refer to section 2.3 for details.
    - HIV/AIDS
    - Tuberculosis
    - Leprosy
    - Systemic Lupus Erythematosus (SLE)
    - Cystic Fibrosis
    - Cancer
    - Hemophilia
    - ESRD - Levels 3, 4 and 5
    - Multiple Sclerosis
    - Scleroderma
    - Pulmonary Hypertension
    - Aplastic Anemia
    - Rheumatoid arthritis
    - Autism
    - Skin cancer
    - Skin cancer: carcinoma IN SITU
    - Skin cancer: Invasive Melanoma or squamous cells with evidence of metastasis
    - Adults with Phenylketonuria
    - Chronic Hepatitis C

- Congestive Heart Failure (CHF), Class III and IV, NHHA in a potential candidate for heart transplant
- Primary Ciliary Dyskinesia (PCD)
- Inflammatory Bowel Disease (IBD): Crohn's disease; Ulcerative Colitis and Microscopic Colitis
- Homebound - If you are homebound, because your health condition does not allow you to leave your home unaided, or leaving the home is not medically recommended, or it involves considerable effort. You must be enrolled in the MCS Classicare Special Conditions Registry and must complete the application titled "Checklist - Homebound Criteria". Applications will be evaluated by a qualified health professional approved by MCS Classicare. Please refer to section 2.3 for details.

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

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

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

What is the role (if any) of the PCP in referring members to specialists and other providers?

Your PCP will refer you for special treatment based on medical necessity. They will fill a referral form in order for you to see a specialist or certain other providers from the network. If you visit a specialist within the Managed Care provider network without a referral from your PCP, you may have to pay for the rendered services.

Please note: Changing your PCP will not affect the services you receive from specialists and other allied health professionals you may use.

Special conditions - registration process

If you are diagnosed with one of the chronic or special conditions mentioned in section 2.2, your PCP, in collaboration with your treating specialist, must request us your inclusion in the Special Conditions Registry. This is the procedure:

1. Your PCP or specialist must identify that your condition is eligible for the registry.
2. Your PCP or specialist must send the Registry Request Form informing the name of the specialist treating your special condition along with the medical information that supports the special or chronic condition diagnosis to MCS Classicare via fax at: 787-622-2436.
3. We will evaluate the request within 5 working days of receipt of the request, to determine if it is complete.
4. If the information is complete we will process the request on or before 30 working days. If the initial

request is not completed, we will request the missing information from your PCP or specialist.

5. You will receive a Special Registry Certification Letter by mail that certifies that you have an eligible special condition.

Some services require pre-authorization (PA) from the plan

There are certain services that require pre-authorization from your plan. The benefits that require pre-authorization and referrals are mentioned in Chapter 4, Section 2.1 of this booklet.

How to request a pre-authorization

You or your provider may send to us, a request for a pre-authorization, via fax at 787-622-2434 or at 787-620-1336 along with the following information:

- Written medical order specifying the service or procedure requested, including:
  - Order emission date
  - Diagnosis description and code and procedure code
  - Name of the member
  - Member's contract number
  - ICD10 code and/or Diagnosis description
  - Procedure service code
  - Name of the provider ordering the service
  - Telephone number of the provider ordering the service
  - Fax number of the provider ordering the service
  - Provider signature, license number and / or National Provider Identifier (NPI)
- Clinical data or provider's support statement justifying the need of the clinical service, such as:
  - Signs and symptoms
  - Previous or current studies and laboratory results related or relevant to the diagnosis and service
  - Previous treatment related or relevant to the diagnosis
  - Specialist's consults and/or progress notes relevant to the diagnosis
  - Please note: Changing your PCP will not affect the services you receive from specialists and other allied health professionals you may use
  - Referrals

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

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

- Even though our network of providers may change during the year, Medicare requires that we

furnish you with uninterrupted access to qualified doctors and specialists.

- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Preauthorization may be required.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

You must receive all your care services through the providers in the network. In some circumstances, you may obtain services from providers outside the network, for example, during an emergency. There are special circumstances where you may get services from out-of-network providers:

- When you get emergency care or urgently needed services outside the service area (see Section 3 in this chapter).
- When you are temporarily outside the plan's service area and have to receive kidney dialysis services (you must receive the service in a Medicare-certified dialysis facility).
- If you need medical care that Medicare requires our plan to cover and there are no providers in our network that provide this service, you can get this care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. Before seeking out-of-network care, you must:
    - Make sure the provider is eligible to participate in Medicare. If you choose a provider that is not eligible, you will be responsible for the full cost of the service;

- Obtain authorization from the plan prior to receiving care from the out-of-network provider;
- Make sure your Primary Care Provider coordinates services with MCS Classicare Platino Total (HMO D-SNP) and the out-of-network provider in order to verify that authorization for services has been obtained.

Please note: The Part D drugs will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation or who do not have a valid record of opting-out of Medicare.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You may call our Call Center (phone numbers are printed on the back cover of this booklet).

What is covered if you have a medical emergency?

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. However, in most cases, your follow-up care may not be covered by our plan if it is acquired from out-of-network

providers or out of the plan's service area. Certain exceptions may apply. See also, Section 2.4 in this Chapter. Please, contact the plan for details.

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

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

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

If you have an urgent situation, you can request service with one of the following programs that are part of your coverage:

- MCS MedilíneaMD by calling 1-833-275-6276 or 1-844-981-1499 (TTY). MCS MedilíneaMD is the telemedicine platform for urgency services included in your coverage. The benefit allows you to receive urgency services without having to visit an emergency room or urgent care center. The MCS MedilíneaMD service is offered by primary care physicians 24 hours a day, 7 days a week to attend to members through a call or video call. For more information about this service, please refer to our Remote Access Technologies benefit in Chapter 4.

- MCS Medilínea calling at 1-866-727-6271. MCS Medilínea is a free telephonic consultation service answered by graduate nurses, 24 hours a day, 7 days a week. These nursing personnel are supported by doctors and specialized clinical personnel. For more information about this service, please refer to our Health and Wellness Education Programs in Chapter 4.

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgent care services outside the United States and its territories under the following circumstances: 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, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.mcsclassicare.com for information on how to obtain needed care during a disaster.

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

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

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

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

Section 4.2 What should you do if services are not covered by our plan?

MCS Classicare Platino Total (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. The costs you pay for those benefits, once the limit is reached, will not count toward your maximum out-of-pocket. For example: if you have a maximum benefit of $1,000 for chiropractor services during a contract year, and you have reached the plan maximum ($1,000) then you will have to pay for the next chiropractor services you want to receive. The

total costs you pay for those extra services will not count towards your maximum out-of-pocket.

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

Section 5.1 What is a clinical research study?

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

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

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

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

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

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

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and

services you receive as part of the study, including:

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

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

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

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

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

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

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

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

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

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

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

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

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

The limit of your Inpatient Hospital Care benefit period may apply. Please, go to the Medical Benefits Chart (what is covered and what you pay) in Chapter 4 for additional information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of MCS Classicare Platino Total (HMO D-SNP), however, you 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.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, MCS Classicare Platino Total (HMO D-SNP) 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 MCS Classicare Platino Total (HMO D-SNP) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of MCS Classicare Platino Total (HMO D-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

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

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

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $3,400.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with the following sign (†) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

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

Here is how this protection works.

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

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

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

The Medical Benefits Chart on the following pages lists the services MCS Classicare Platino Total (HMO D-SNP) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.

- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including the cost sharing for prescription drugs. Medicaid also covers services Medicare does not cover, like family planning.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.
- This plan integrates Medicare and Medicaid benefits. However, a separate section contains Platino Wrap-Around Benefits.
- If you are within our plan's six (6) month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will continue to cover Medicaid benefits that are included under the Medicaid State Plan, and we will pay the Medicare premiums and/or cost sharing for which the state would be liable. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

- Because MCS Classicare Platino Total (HMO D-SNP) participates in Wellness and Health Care

Planning (WHP) Services, you will be eligible for the following WHP services, including advance care planning (ACP) services:

- Our Wellness and Health Planning (WHP) service seeks to give you timely opportunities to determine, along with your Primary Care Provider, any advance directives and health care planning wishes that are important to you. MCS Classicare will request from you, at different moments, your wishes about the level of treatment and care you desire in case you become unable to make these decisions yourself. Your designated caregivers may also participate in this process. Your participation is voluntary, and you are free to opt out at any time.
- Our Care Management Program can also perform a Comprehensive Health Risk Assessment (CHRA) to evaluate your overall health status. During this screening, you will be asked if you are aware that you have the right to accept or refuse treatment. The following are some of the topics that your provider or your Care Manager will discuss with you as part of the Wellness and Health Planning service:
  - What are advance directives;
  - How you can include advance directives to your health care plans;
  - Who can assist you if you are interested in including advanced directives to your health care plan; and
  - Information on how advance directives and health care planning instructions are kept in your medical and care management records.
- You will be informed annually about your health care planning and WHP-related instructions. This could be during your Annual Wellness Visit or during any other visit with your provider. These visits are an opportunity for you to make any changes to your advance directives. Please contact your assigned Care Manager for more information about advanced directives or any other particular health care planning considerations you may have.

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
NOTES: • *Cost share is based on the service received and the setting where it is performed. Additional cost share may apply when other services are performed.* • † = *Cost-sharing does not count for your maximum out-of-pocket. See Section 1.2 in this Chapter.* • *Legend for column titled: **"What You Must Pay"**: $ (copayment), % (coinsurance). See Chapter 12 (Definitions of important words.)* • *Coverages 100, 110, 120 and 130: If you have questions about your Medicaid eligibility and to know your level of cost-sharing, contact the Health Department's Medicaid Office. See Chapter 2, Section 6 for information about how to contact the Health Department's Medicaid Office.*	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.	$0 copayment for each Medicare-covered service.

Services that are covered for you	What you must pay when you get these services
Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Additional Acupuncture Services Additional Acupuncture services – without the need for diagnosis – are limited to 6 visit(s) every year. These services must be furnished by network providers. Rules and limitations may apply. Please contact the plan for more details.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$0 copayment for each Medicare-covered Ground Ambulance service. $0 copayment for each Medicare-covered Air Ambulance service. *Prior Authorization may be required.*
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
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 age 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.* $0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation **Routine chiropractic care** Limited to 6 non-Medicare covered routine visit(s) every year (for other non-Medicare covered diagnoses). Please contact the plan for more details.	$0 copayment for each Medicare-covered service. *Referral may be required.* $0 copayment † *Referral may be required.*

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. There is no copayment for the diagnostic exam.

Services that are covered for you	What you must pay when you get these services
• Medicare-covered Barium Enema Preventive Services	$0 copayment for each Medicare-covered service.
Dental services **Medicare-covered dental services** Medicare Part A will pay for certain dental services that a beneficiary receives when they're in a hospital. Medicare can pay for hospital stays if a beneficiary needs to have an emergency or complicated dental procedure. In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. We also cover other dental services required by Medicare under medical coverage. In addition, we cover:	$0 for Medicare-covered dental benefits.
Diagnostic Services † • One (1) initial comprehensive oral evaluation per provider every thirty-six (36) months, up to two (2) per policy year, with different provider and different dental office. • One (1) periodic oral evaluation every six (6) months. • A detailed and extensive oral evaluation - problem focused, one (1) per policy year. Limited to oral and maxillofacial surgeon. • Comprehensive periodontal evaluation, one (1) per policy year. Limited to periodontist. • Limited oral evaluation – problem focused (emergency oral evaluation) one every six (6) months. For endodontists, an evaluation applies when medically necessary. • One (1) complete (full mouth) or panoramic series every three (3) years. If there is evidence of similar services in the patient’s history, this will probably be time limited. This	$0 copayment per office visit for preventive and diagnostic dental services not covered by Medicare (but covered by the plan). No maximum benefit coverage applies for preventive and diagnostic services.

Services that are covered for you	What you must pay when you get these services
benefit does not apply if there are six (6) intraoral periapical radiographic images in a period of one (1) year. • Six (6) intraoral periapical radiographic images per policy year. This benefit will be limited if a complete series of intraoral periapical radiographic images or one (1) extraoral panoramic radiographic image has been benefited. • One set of one (1) set radiographic bitewing images per policy year. • A pulp vitality test by visit, without taking into consideration the number of teeth examined. A vitality test will be considered every six (6) months, if necessary. This limitation does not apply to endodontist. • Cone beam CT for both jaws, when medically necessary, with or without cranium one (1) per policy year. **Preventive Services** † • One (1) oral prophylaxis every six (6) months. • Topical application of fluoride, excluding varnish, every six (6) months. This service applies for patients up to them turning 19 years of age. • Fissure sealant per tooth. This service is limited to one (1) per tooth per life in unrestored posterior permanent for patients up to them turning 14 years of age. Decidual molars up to turning 8 years old will be covered when medically necessary because of cavity tendencies. **Minor restorative services** † • Amalgam restorations in primary and permanent posterior teeth will be covered every twenty-four (24) months. If the dentist needs to redo a previous restoration and add a surface, only the added surface will be covered. The areas previously covered will be patient's responsibility. • Resin-based composite restorations in all surfaces will be considered every twenty-four (24) months. If the dentist needs to redo a previous restoration and add a surface, only the added surface will be covered. The areas previously covered will be patient's responsibility. **Other restorative services** †	\$0 copayment for non-routine services, restorative services including crowns, endodontics, periodontics, extractions and oral surgery. \$1,200 every year – plan coverage limit for non-routine services, restorative services including crowns, endodontics, periodontics, extractions, oral surgery, prosthodontics, and dental services not covered by Medicare (but covered by this

Services that are covered for you	What you must pay when you get these services
• Sedative protective restorations for teeth with deep cavities is limited to one (1) per tooth per life. • Pin retention is limited to one (1) treatment per tooth every twenty-four (24) months, in addition to the restoration. • Core buildup, including any pin when required, is limited to one (1) per tooth every five (5) years. • Post and core, in addition to crown is limited to one (1) per tooth per life. **Major restorative †:** Major restorative benefits, including crowns and prosthetics, have limited coverage per tooth. If the treatment fails and a new treatment plan involves the already benefited tooth, coverage will be the patient's responsibility. **Crowns †** • Porcelain/ceramic crown; • Porcelain/metal crown; • Metal crown; • Stainless steel crown; • Indirect and prefabricated resin crown/¾ resin crown. * All crowns are limited to one (1) per tooth every five (5) years. • Recement or reattach crowns is limited to one (1) per tooth per life, six (6) months after initial cementation. • If a crowned tooth needs to be replaced, no benefits from fixed prostheses or implants will be granted to the patient until five (5) years after cementation. **Endodontic services †** • Endodontic therapy (root canal) in all permanent teeth is limited to one (1) per tooth per life for each service. • Pulpotomy is limited to one (1) per tooth per life. • Pulp debridement is limited to one (1) per tooth per life. • Direct or indirect pulp capping is limited to one (1) per tooth per life. • Endodontic retreatment for previously endodontically treated teeth, which are symptomatic or present periapical	plan). After the annual maximum is exhausted, any remaining charges are the member's responsibility.

Services that are covered for you	What you must pay when you get these services
radiolucency is limited to one (1) per tooth per life. **Periodontic services** † • Gingivectomy or gingivoplasty is limited to one (1) per quadrant every twenty-four (24) months only for gingival hyperplasia with minimal bone loss. • Periodontal scaling is limited one (1) per quadrant every twenty-four (24) months. • Full mouth debridement to enable comprehensive evaluation and diagnosis is limited to once (1) per life. • Gingival flap procedure is limited to one (1) of the following procedures every three (3) years per quadrant. Limited to periodontist. Limited if you have already benefited from bone surgery. • Clinical crown lengthening – the hard tissue is limited to one (1) per tooth per life, and to one (1) procedure per quadrant every twelve (12) months. • Osseous surgery per quadrant is limited to one (1) of these procedures per quadrant every three (3) years. Limited to periodontist. Limited if you have already benefited from a gingival flap. • Bone replacement graft first site, per quadrant, is limited to one (1) per quadrant every three (3) years. Not to be reported for an edentulous space or an extraction site. Only for retained natural teeth. Limited to periodontist. • Bone replacement graft additional site, per quadrant, limited to one (1) every three (3) years. Not to be reported for an edentulous space or an extraction site. Only for retained natural teeth. Limited to periodontist. • Soft tissue graft procedure one (1) per quadrant every three (3) years. Limited to periodontist. • Periodontal maintenance is limited to one (1) every six (6) months after an oral prophylaxis or periodontal maintenance. Limited to periodontist. **Oral surgery** †	

Services that are covered for you	What you must pay when you get these services
Covered oral surgery services are as follows: • Removal of erupted tooth or surgical extractions is limited to one (1) per tooth for life. • Removal of impacted teeth (tissue or bone) is limited to one (1) per tooth for life. • Removal of residual dental root is limited to one (1) per tooth for life. • Incision and drainage of soft tissue abscess is limited to one (1) per quadrant per policy year. • Removal of exostosis (maxilla or mandible), removal of torus palatinus or torus mandibularis is limited to one (1) per arch every five (5) years. • Frenectomy is limited to one (1) per arch for life. • Closure of oroantral fistula limited by exposure. **Other surgical procedures limited to oral and maxillofacial surgeons** † • Primary closure of maxillary sinus perforation. Limited by exposure. • Tooth reimplantation or stabilization of displaced or avulsed tooth caused by accident. Limited to one (1) per tooth for life. • Surgical access of an unerupted tooth; limited to one (1) per tooth for life. • Incisional biopsy of oral tissue (soft and hard); limited to one (1) per lesion. • Surgical repositioning of tooth limited to one (1) per tooth for life. • Alveoloplasty in conjunction with extractions; limited to one (1) per arch for life. • Alveoloplasty not in conjunction with extractions; limited to one (1) per quadrant for life. • Vestibuloplasty limited to one (1) per arch for life. **Other Services** † • Palliative treatment to treat pain - minor procedure is limited	

Services that are covered for you	What you must pay when you get these services
to one (1) every twelve (12) months. • Deep or moderate sedation is covered for extractions and removal of impacted teeth, when performed in a dental office. The first fifteen (15) minutes are covered, and a single additional increment of fifteen (15) minutes, for a maximum of thirty (30) minutes. Covered only for extractions, and for other services covered with medical justification. Limited to oral and maxillofacial surgeon and pediatric dentist. • Visits to hospitals or ambulatory surgical centers for dental treatments. • Occlusal adjustment limited or complete. Covered only for patients active in periodontal treatment.	
Prosthodontic services † The same prosthodontic service coverage limit amount applies for all covered prosthetic services. These services are covered according to the rules and limitations of the contract. All prosthodontic services require an adaptation period. Prosthodontic benefits include adjustments as needed for the first six (6) months. Patient is responsible for contacting the dental provider if discomfort for evaluation. If the treatment fails and a new treatment plan involves the already benefited tooth or arch, coverage for the new treatment will be the patient's responsibility *Removable Prosthodontia* † The following prosthetic services are covered in accordance with the American Dental Association standards of care and with radiographic evidence. Limited to one (1) per arch every five (5) years. Removable prosthetics limit each other, and other prosthetics restorations previously made, may limit the benefit. • Complete removable dentures. • Complete immediate removable dentures. • Removable partial dentures acrylic or metal base. • Maxillary and mandibular provisional partial dentures. • Removable unilateral partial denture (resin, metal and flexible	$0 copayment for prosthodontics: Removable, fixed and implants.

Services that are covered for you	What you must pay when you get these services
base). • Flexible removable partial dentures. Adjustments, replacements, and repairs are not covered for flexible partial dentures. • Removable complete and partial dentures implant supported. • Repairs and adjustments of full mandibular or maxillary broken dentures, partial maxillary or mandibular dentures are covered one (1) adjustment, and two (2) repairs per year after six (6) months of initial delivery, if necessary. • Relines and rebase, as well as tissue conditioning, are limited to one (1) every five (5) years. *Fixed prosthesis* † The following prosthetic services are covered in accordance with the American Dental Association standards of care and with radiographic evidence. Fixed bridge limited to one (1) per tooth per life as detailed. • Pontic (metals) (teeth to be replaced). • Pontic porcelain-fused-to-metal (teeth to be replaced). • Pontic porcelain/ceramic (teeth to be replaced). • Porcelain-fused-to-metal retainer crown. • Porcelain/ceramic retainer crown. • Metal retainer crown. • Re-cement or re-bond fixed prosthesis is limited to one (1) per tooth per life and covered after six (6) months of original cementation. *Implants services* † The following services are covered in accordance with the American Dental Association standards of care and with radiographic evidence. • Endosteal implant surgery to replace teeth are covered once (1) per tooth per life. • Prefabricated or custom fabricated abutments are covered once (1) per tooth per life.	

Services that are covered for you	What you must pay when you get these services
• Single crowns, abutment-supported or implant- supported (all metal or porcelain fused to metal noble or high noble or porcelain) are covered once (1) per tooth per life. Crowns and pontics fixed bridge implant or abutment supported will be covered once (1) per tooth per life including all metal or porcelain fused to metal noble or high noble or porcelain. Only pontics to substitute missing natural teeth using the normal number of abutments for the span will be covered once (1) per tooth per life. If a fixed bridge component requires replacement with an implant or crown, the patient will not be granted the benefit again until five (5) years after cementation. Semi precision supporting structure for removable prosthesis over implants are covered once (1) per tooth per life. These services may be offered by a certified provider. These services are covered according to the rules and limitations of the contract. Mini implants or any restoration associated with mini-implants will not be covered. Implants must have the FDA seal and ID of approval. Dental procedures not mentioned in this document are considered not covered. NOTE: If your plan does not have a Point of Service option, dental services will not be covered for out-of-network providers. The following services are considered general exclusions and must be applied in all cases, unless MCS states otherwise, in writing, and due to the individual coverage design of a particular group:	Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
1. Services provided for cosmetic purposes. 2. Services provided to correct a vertical dimension or occlusion. 3. Ferulization crowns for teeth with periodontal problems. 4. Total maxillary or mandibular reconstructions. 5. Fixed bridge, at the same time as a partial bridge in the same arch, to replace teeth in posterior areas, only partial bridge will be considered. 6. Services related to Temporomandibular Joint Syndrome (TMJ). 7. Instructions related to oral hygiene and diets. 8. Replacement of a fixed bridge with a removable bridge due to allergy reasons. 9. Replacement of lost prostheses. 10. Diastema closure for cosmetic reasons. 11. Any other service not expressly included in the member's benefit coverage. 12. Dental treatments that are considered experimental or that are not considered part of the standard of care, as established by national professional associations. 13. Combined support for fixed bridges of natural teeth with implants. *Some services may require preauthorization, contact the plan for details.* *If you have questions, ask your dental health professional or call our plan.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. Diabetic Supplies and Services are limited to those from specified manufacturers. Contact the plan for more information. Certain services or items require referral from your PCP through Referral/Authorization Form. Contact the plan for more details.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.* $0 copayment for each Medicare-covered service. *Prior Authorization may be required.* $0 copayment for each Medicare-covered service.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*
With this *Evidence of Coverage* document, we sent you MCS Classicare Platino Total (HMO D-SNP)'s list of DME. The list tells you the brands and manufacturers of DME that we will cover. This most recent list of brands, manufacturers, and suppliers is also available on our website at www.mcsclassicare.com. Generally, MCS Classicare Platino Total (HMO D-SNP) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to MCS Classicare Platino Total (HMO D-SNP) and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).)*Certain services or items require referral from your PCP through Referral/Authorization Form. Contact the plan for more details.	Your cost sharing for Medicare oxygen equipment coverage is $0, every month. Your cost sharing will not change after being enrolled for 36 months in MCS Classicare Platino Total (HMO D-SNP). If prior to enrolling in MCS Classicare Platino Total (HMO D-SNP) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MCS Classicare Platino Total (HMO D-SNP) is $0.

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	$0 copayment for each Medicare-covered service. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
Worldwide coverage (out of network): Worldwide coverage includes emergency care and urgent services outside the United States and its territories. Coverage is managed through reimbursement based on different fee schedules allowed by our plan, which are applied according to the service received, less the corresponding cost sharing amount. Please contact the plan for more details.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Foot Reflexology Medically necessary, non-pharmacologic pain management alternatives are available to you. You may find relief from foot reflexology. This therapy stimulates the nerves so pain signals are interrupted from travelling to other parts of the body. Foot reflexology services are limited to 6 visits per year. These services must be ordered by a physician or a medical professional; and must be furnished by network providers. Additional visits are the enrollee's responsibility, and payable according to regular health care fees. **Reimbursement does not apply. Rules and limitations may apply. Contact the plan for information.**	$0 copayment. †
Health and wellness education programs As part of MCS Advantage, Inc.'s commitment to the health of our affiliates, we have developed initiatives and innovative wellness programs designed especially for you that complement the basic benefits of our plans to help you achieve your optimum health. These Wellness Programs, oversee your health as a holistic aspect, offering you a variety of experiences towards the benefit of your social, emotional, intellectual, and physical health in order to meet expectations of what a complete health plan should offer. **Healthy Welcome Program** • After your enrollment, you will receive a call to help you coordinate your first complete health evaluation appointment with your physician. • This service allows us to offer you the continuous and preventive care you need, according to your medical history. • MCS Classicare Platino Total (HMO D-SNP) will help you establish an effective relationship with your physician and become more involved in the decisions about your healthcare.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Health Education Through our Health Education initiatives, you will receive a variety of experiences to enhance your health. We offer you activities (both online and face-to-face) that promote social, emotional, intellectual, and physical health. These include: • Health lectures: Includes topics for Care Management such as chronic health conditions including diabetes, cardiovascular health, chronic kidney disease, respiratory conditions, bone health among others; preventive health which include mental health, health monitoring, nutrition and physical activity. • Preventive reminders: To promote healthy actions that leads to early detection and management of certain health conditions. • Support interventions: Provide interventions to improve quality of life in a holistic approach. The topics include financial education, social services, hygiene, gardening, arts among others. • Exercise Program: This benefit allows you to participate in exercise sessions offered by certified fitness instructors, and other health professionals through which you will learn about concepts and techniques aimed at helping you maintain an active life. You will be able to participate in exercise sessions held at various places in the Island.	$0 copayment †
MCS En Alerta • Offers educational campaigns about safety measures regarding hurricanes, earthquakes, and other natural disasters, among other events. We provide health seminars, educational materials, media tours among others	$0 copayment †

Services that are covered for you	What you must pay when you get these services
MCS Medilínea • This is a free health consultation phone service staffed by registered nurses 24 hours a day, seven (7) days a week. This nursing staff, supported by physicians and specialized clinical personnel, offers practical help and guidance about common conditions, drugs and their possible side effects, and lab results, among others. • Whenever you feel ill and don't know what you should do or have any doubts about the use of a drug contact MCS Medilínea, available 24 hours a day, seven (7) days a week. For more information about any of our Health and wellness programs, call our Call Center. To contact MCS Medilínea, please call 1-866-727-6271.	$0 copayment †
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	$0 copayment for each Medicare-covered service.
Additional routine hearing exams Limited to 1 visit(s) every year Please contact the plan for more details.	$0 copayment †
Fitting-evaluation(s) for hearing aids Limited to 1 visit(s) every year Please contact the plan for more details.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Hearing aids Please consult "Combined Eyewear and Hearing Allowance" benefit at the end of this chart.	Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for each Medicare-covered service. *Referral is required.* *Prior Authorization is required.*

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *Some services may require preauthorization, contact the plan for details.*	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you 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 MCS Classicare Platino Total (HMO D-SNP). There is no cost-sharing for hospice consultation.

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

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. The plan covers 90-days each benefit period. You also have 60 lifetime reserve days, which can be used only once. Refer to the section entitled Benefits Covered by the Puerto Rico Department of Health's Medicaid Program for information regarding your extended coverage under this plan.	$0 copayment for each Medicare-covered hospital stay.

Services that are covered for you	What you must pay when you get these services
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services	Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The hospital cost-sharing is charged on the date of admission, except for emergencies. *Referral may be required.* *Prior Authorization may be required.*

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If MCS Classicare Platino Total (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. ○ Transplant travel benefit - If you are sent by our Plan outside of your community (outside Puerto Rico) for a Medicare-covered transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion up to $10,000†, through reimbursement. Certain restrictions may apply, contact the plan for details. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† that you need. All components of blood are covered beginning with the first pint used. • Physician services	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. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay You get up to 190 days of inpatient psychiatric hospital care during your lifetime. Inpatient psychiatric hospital services count towards the 190-day lifetime limit only if certain conditions are met. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. *Some services may require preauthorization through MCS Solutions and certain exceptions may apply.* *For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	$0 copayment for each Medicare-covered hospital stay. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
	Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The cost-sharing is charged on the date of admission and does not include the date of discharge. *Prior Authorization may be required.*
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
• Physician services	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.
• Diagnostic tests (like lab tests)	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.

Services that are covered for you	What you must pay when you get these services
• X-ray, radium, and isotope therapy including technician materials and services	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Surgical dressings	Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Splints, casts and other devices used to reduce fractures and dislocations	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• 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	Please refer to Prosthetic Devices and Related Supplies.
• 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	Please refer to Prosthetic Devices and Related Supplies.
• Physical therapy, speech therapy, and occupational therapy *Some services may require preauthorization, contact the plan for details.* Some services or items require referral from your PCP. Please refer to Chapter 3, Section 2.2 for exceptions and important information about referrals.	Please refer below to Outpatient Rehabilitation Services.

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

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Multiple Sclerosis agents, drugs to treat rheumatoid arthritis, drugs to treat Crohn's Disease, drugs to treat psoriatic arthritis, and drugs to treat ulcerative colitis, and drugs to treat cancer • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug	$0 copayment for each Medicare-covered service. *Prior Authorization is required.* Applies only for all other Medicare Part B drugs (not including Part B chemotherapy/radiation drugs).

Services that are covered for you	What you must pay when you get these services
• Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.mcsclassicare.com/en/Pages/prescription-coverages/prescription-drug-part-b.aspx. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	0% for Medicare Part B Radiation Drugs. 0% for Medicare Part B Chemotherapy Drugs. *Prior Authorization may be required.* Some Part B drugs may be subject to step therapy requirements. Step therapy is a type of prior authorization for drugs that encourages you to try the most preferred drug therapy for a medical condition, progressing to other therapies only if necessary, to promote better clinical decisions.
Nutritionist Services Limited to 6 visit(s) for individual sessions every year. All our enrollees may receive a personal evaluation and diet plan designed by a licensed dietitian according to their health needs, including exercise suggestions. Any vitamin, supplement or item recommended from such evaluation may not be covered. Please see your Providers and Pharmacies Directory for a list of available dietitians. If you want to change your provider after the initial visit, you should contact the plan before making any changes.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments For details before receiving services, contact the plan.	$0 copayment for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays	$0 copayment for each Medicare-covered service. *Referral may be required. Prior Authorization may be required.*

Services that are covered for you	What you must pay when you get these services
• Radiation (radium and isotope) therapy including technician materials and supplies	$0 copayment for each Medicare-covered service. *Referral may be required.*
• Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
• Laboratory tests	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† that you need. All components of blood are covered beginning with the first pint used.	$0 copayment for each Medicare-covered service.
• Other outpatient diagnostic tests - Non-radiological diagnostic services	$0 copayment for each Medicare-covered service. *Referral may be required. Prior Authorization may be required.*
• Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays	$0 copayment for each Medicare-covered service. *Referral may be required. Prior Authorization may be required.* Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

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

Services that are covered for you	What you must pay when you get these 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 • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copayment for each Medicare-covered service. *Referral is required.* *Prior Authorization is required.*
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	

Services that are covered for you	What you must pay when you get these services
• Services provided by a psychiatrist	$0 copayment for each Medicare-covered Individual Session. $0 copayment for each Medicare-covered Group Session.
• Services provided by other mental health care providers	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization is required.* $0 copayment for each Medicare-covered Group Session.
Some services may require preauthorization through MCS Solutions and certain exceptions may apply. *For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
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).	
• Services provided by a physical therapist or speech language therapist	$0 copayment for each Medicare-covered service. *Prior Authorization is required.*

Services that are covered for you	What you must pay when you get these services
• Services provided by an occupational therapist	$0 copayment for each Medicare-covered service. *Prior Authorization is required.* Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
Outpatient substance abuse services Our plan covers treatment for alcoholism and substance dependence in outpatient settings. The outpatient substance dependence treatment services include: • Screening and counseling for people who show signs of alcohol misuse or other substances • Assessment to quickly determine the severity of substance use and identify the appropriate level of treatment • Brief counseling focused on awareness and understanding of substance use and motivation toward behavioral change • Patient education regarding diagnosis and treatment • Structured assessment; services provided in a psychiatrist or psychologist's office in outpatient services clinic • Group and individual therapy *Call MCS Solutions at 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	$0 copayment for each Medicare-covered Individual Session. $0 copayment for each Medicare-covered Group Session. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
• Services provided at an outpatient hospital	$0 copayment for each Medicare-covered service. *Referral is required.* *Prior Authorization is required.*
• Services provided at an ambulatory surgical center	$0 copayment for each Medicare-covered service. *Referral is required.* *Prior Authorization is required.* Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
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 is more intense than the care received in your doctor's or therapist'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 is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. *For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	$0 copayment per day for each Medicare-covered service. Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include:	
• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	$0 copayment for each Medicare-covered service. See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.
• Consultation, diagnosis, and treatment by a specialist	$0 copayment for each Medicare-covered service. *Referral is required.*
• Other health care professionals	$0 copayment for each Medicare-covered service. *Referral is required.*
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	$0 copayment for each Medicare-covered service.

Services that are covered for you	What you must pay when you get these services
• Certain telehealth services, including: Primary Care Physician Services, Physician Specialist Services, Individual Sessions for Mental Health Specialty Services, Individual Sessions for Psychiatric Services, and Diabetes Self-Management Training. In the Providers and Pharmacies Directory, you may check to see if your doctor offers telehealth services. The doctors that offer this service are identified under the Telemedicine category in the directory. On the day of your appointment, if you previously agree with your doctor to receive the service, you will receive a link on your cellphone, tablet, or computer that you may use to access your appointment with your doctor via MCS TeleCare (Telemedicine Service). ○ 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. ○ To learn about the available means of electronic exchange used for the telehealth services previously listed, along with any other access instructions that may apply, call our Call Center. • 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	$0 copayment for each Medicare-covered service. †
• 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	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Services that are covered for you	What you must pay when you get these services
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Services that are covered for you	What you must pay when you get these services
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Second opinion by another network provider prior to surgery	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• 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)	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.* Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copayment for each Medicare-covered service. *Referral may be required.* Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam	$0 copayment for each Medicare-covered service.

Services that are covered for you	What you must pay when you get these services
• Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail. Only Medicare-covered intraocular lenses are covered. Certain services or items require referral from your PCP through Referral/Authorization Form. Contact the plan for more details.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.* Applies only for each Medicare-covered prosthetic device.
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.	$0 copayment for each Medicare-covered service.
Remote Access Technologies (MCS medilíneaMD) MCS medilíneaMD provides Remote Access Technology services, better known as Telemedicine, that allow you to receive urgent medical care from anywhere within Puerto Rico, 24 hours a day, 365 days a year. You have access to health consultations for a minor illness with a general practitioner or licensed emergency physician. Telemedicine visits can be done by smartphone, computer or tablet. Children under eighteen (18) years must be accompanied by an adult at the time of consultation. Consulting conditions for this service include but are not limited to: allergies, runny nose, nasal congestion, sneezing, constipation, cough, diarrhea, ear problems, moderate fever, flu, headache, insect bites, nausea, conjunctivitis, skin rash, sore throat and vomiting. In severe cases and those in which the doctor understands merit the	$0 copayment †

Services that are covered for you	What you must pay when you get these services
use of prescription drugs according to the patient's clinical history, a prescription will be sent directly to a network pharmacy of the enrollee's choosing. If the doctor determines that the patient's condition cannot be treated through this Telemedicine platform, the patient shall be referred to an emergency room, an urgency center or his/her primary doctor. The patient is responsible for checking their Evidence of Coverage and Prescription Drug Formulary to determine whether MCS Classicare shall cover certain prescriptions. This service does not replace your doctor. This service does not include consultations with medical specialists or sub-specialists, except for those mentioned previously. It does not apply for services outside the contracted Telemedicine platform. Reimbursement does not apply. Refill prescriptions or prescriptions for supplies higher than thirty (30) days shall not be issued. Prescriptions for maintenance medications shall not be issued. Prescriptions for controlled substances as described by the Drug Enforcement Administration (DEA), non-therapeutic medications, or other drugs that may be harmful due to their potential for abuse will not be issued. You will be able to have a virtual visit via MCS medilíneaMD through the Mi MCS application or toll free at 1.833.275.6276 or 1.844.981.1499 TTY.	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include:	
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$0 copayment for each Medicare-covered service.
• 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)	$0 copayment for each Medicare-covered service.
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for each Medicare-covered service.
• Home dialysis equipment and supplies	Please refer to Durable Medical Equipment and Related 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)	Please refer to Home Health Agency Care.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section **Medicare Part B prescription drugs**.	

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) A prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† that you need. All components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	$0 copayment for each Medicare-covered skilled nursing facility stay. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. *Referral is required.* *Prior Authorization is required.*

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special Supplemental Benefits † Based on socioeconomic status, all members in this plan are eligible for Special Supplemental Benefits. If you wish to decline these benefits or if you have questions regarding these benefits, please call our Call Center at 787.620.2530 (Metro Area) or 1.866.627.8183 (Toll Free). (TTY users should call 1.866.627.8182). Our hours of operations are: • From October 1 to March 31: Monday through Sunday from 8:00 a.m. to 8:00 p.m. • From April 1 to September 30: Monday through Friday from 8:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 4:30 p.m. If you do opt out, you may be allowed to reenter to receive Model Benefits (by communicating with our Call Center). Additional benefits include: **Te Paga Card** Members may use their allowance to purchase both OTC and additional items with your Te Paga card. You will be able to use Te Paga for any of the following: • OTC Items • Food and produce, and prepared foods	$0 copayment. You have up to $250 monthly ($3,000 annually).

Services that are covered for you	What you must pay when you get these services
• Utilities: Electricity, water, telephone, cable, Internet • Pest control items • Pet food and supplies • Indoor air quality equipment and services: Air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance and repair services. • General supports for living: Gasoline and auto repairs; cleaning products; hardware/tools to support house maintenance/ appliances. • Hurricane preparedness items: First aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. • Social needs: Club memberships, park passes, and musical events. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to these events/activities • Services supporting self-direction: Classes in technology, language, financial and other types of supporting courses, continued education. • Physical fitness: Items, sports equipment, and services related to improving physical activity. • Memory fitness: Items and services supporting cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking, drawing, painting, language, musical instrument, and meditation classes • Complementary therapies: Mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture; natural products, including plant-based products, dietary supplements, and prebiotic or probiotic products Electricity, water, phone and Internet bills must be in the member's name in order to access the benefit. Unused allowance amount will be carried over to the next month. At the end of the policy year, the plan will not provide any remaining balance of your benefit. If the transaction exceeds the available balance, you must pay the	

Services that are covered for you	What you must pay when you get these services
difference. Cash withdrawal is not allowed. This benefit does not apply for reimbursement. This benefit cannot be used to buy alcoholic beverages nor tobacco or its derivatives. MCS is not responsible for any product or item defects. If any defect is found, you must contact the service provider directly or the product manufacturer. Applies only through contracted suppliers. Restrictions may apply. Contact the plan for details.	

Services that are covered for you	What you must pay when you get these services
Home Assistance Services • Home Assistance services include: plumbing, locksmith, electricity, preventive home cleaning/disinfection, pest control, technology assistance, yard clean-up, and hairstyling (wash, cut, and dry). • For hairstyling services, you must visit participating establishments to receive these services. • Services are limited to twelve (12) visits per year. A maximum of three (3) visits applies per quarter. If the full number of visits is not used in a quarter, the balance of visits is not carried over to be used in the next quarter. Quarterly periods are from January to March; from April to June; from July to September; and from October to December. • Only simple repairs and basic services apply for this benefit, according to the evaluation performed by the service supplier. • Repairs will be made only if damages are related to the member's home and if they occurred inside of the home itself. • MCS Classicare is not responsible of any defect in manufacture of any certain products or items. If any defect is found, you must contact the service supplier or the product manufacturer directly. • Applies only through contracted suppliers. • Reimbursement does not apply. • Restrictions may apply. Contact the plan for details.	$0 for home assistance services.
Transportation for non-medical needs • In addition to enjoying the transportation benefit to attend medical appointments, pharmacies and laboratories, you have the ability of using this benefit for non-medical matters. For example, going to the grocery store or the bank, among others. • Applies only to plan approved locations through contracted suppliers. • Restrictions may apply. Contact the plan for details.	$0 for each one-way trip or return trip each year. Each one-way trip or return trip means one individual trip. **The Transportation for Non-Medical Needs is combined with the base package transportation for health-related needs.** Please refer to your transportation

Services that are covered for you	What you must pay when you get these services
	benefit for information on the number of trips that are available for you. The trips you take for non-health related destinations count against the total trips available under the transportation benefit.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Therapeutic massage Medically necessary, nonpharmacologic pain management alternatives are available to you. You may find relief from therapeutic massage, which helps break the "pain" cycle whilst reducing associated muscle tightness, among other benefits.	$0 copayment †

Services that are covered for you	What you must pay when you get these services
Therapeutic massage services are limited to 6 visits per year. These services must be ordered by a physician or a medical professional and must be furnished by network providers. Additional visits are the enrollee's responsibility, and payable according to regular health care fees. Reimbursement does not apply. Rules and limitations may apply. Please contact the plan for more details.	
Transportation Transportation is one of the benefits included in your health plan. Routine transportation for up to 30 trips every year. A trip is considered one-way transportation to a plan approved health-related location through contracted suppliers. Certain limitations and requirements apply. Please contact the plan for more details.	$0 copayment †
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition, but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	$0 copayment for each Medicare-covered service.

Services that are covered for you	What you must pay when you get these services
Worldwide urgent care coverage (out of network): Worldwide coverage includes emergency care and urgent services outside the United States and its territories. Coverage is managed through reimbursement based on different fee schedules allowed by our plan, which are applied according to the service received, less the corresponding cost sharing amount. Please contact the plan for more details.	$0 copayment †
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	$0 copayment for each Medicare-covered service.
• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older	$0 copayment for each Medicare-covered service.
• For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copayment for each Medicare-covered service.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$0 copayment for each Medicare-covered service.
Routine eye exam Limited to 1 visit(s) every year Please contact the plan for more details.	$0 copayment †
Additional routine eyewear Please consult "Combined Eyewear and Hearing Allowance" benefit at the end of this chart.	Refer to the section entitled *Benefits Covered by the Puerto Rico Department of Health - Medicaid Program* for information.

Services that are covered for you	What you must pay when you get these services
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit. • Medicare-covered EKG following Welcome Visit Preventive Services	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. $0 copayment for each Medicare-covered service.
Wellness and Healthcare Planning (WHP) with Advance Care Planning (ACP) At the beginning of your plan year, you and your primary care provider will make an appointment for a Comprehensive Health Risk Assessment (CHRA). During this assessment, your doctor will ask you about Wellness and Healthcare Planning with Advance Care Planning. Wellness and Healthcare Planning helps you to set health care goals so you can feel your best. Advance Care Planning helps you and your doctor determine the type of care you want to receive if you become unable to communicate for yourself. **This is a Special Medicare Initiative** This Model Benefit is offered as part of a Medicare initiative to increase the quality and decrease the cost of care for beneficiaries in the Medicare Advantage program. Not all Medicare Advantage Organizations or products participate in this initiative. To bring this benefit to you, MCS Classicare may only offer Model Benefits that consist of additional benefits and Wellness and Healthcare Planning Services. MCS Classicare may not offer a plan that reduces available benefits or increases cost-sharing. Remember, as an MCS Classicare enrollee, you retain the right to file	There is no copayment for eligible enrollees.

Services that are covered for you	What you must pay when you get these services
a grievance, or an appeal of a determination related to Model Benefits. This must include the timely provision of an organizational/coverage determination, and grievance/appeal information required for enrollees eligible for Model Benefits. (For more information, see Chapter 9, (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). You can opt out of receiving additional benefits or communications related to this Model. If you choose not to participate, you may be allowed to re-join to receive Model Benefits. Please, call us if you have questions about the Model Benefit, including questions about eligibility. See Chapter 2, Section 1 for plan contact information.	
Combined Eyewear and Hearing Allowance MCS will cover the following services under a combined amount of $800 every year for Eyewear and Hearing items: • Supplemental eyewear (Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames. • Eyewear benefit maximum amount includes repair of eyewear. • Two (2) hearing aids (all types) every year; both ears combined. • For hearing aids, the benefit and maximum plan coverage amount includes repair for hearing aid devices. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. Intraocular lenses are covered under the "Prosthetic Devices and Related Supplies" benefit and apply only to Medicare-covered items.	$0 copayment † *Referral may be required.* *Prior Authorization may be required.* Applies only for Hearing Aids.

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Benefits Covered by the Health Department's Medicaid Program	
The benefits provided by our plan and described below are covered by the Health Department's Medicaid Program. The benefits described in the Medical Benefits Chart (above) are covered by Medicare and our plan. Referrals 1. When a patient is referred to a specialist by a PCP and the specialist prescribes a medication, no countersignature of the prescription will be required from the PCP, as established by CMS. 2. For cases where the MAOs has contracted with Primary Medical Groups (PMGs), who have directly contracted preferred provider specialists, a referral from the PCP is not necessary when both are part of the same PMG. However, the specialists will be required to inform the PCP about the medical services referred. 3. Patients will be able to see specialists such as a Gynecologist/Obstetrician and Urologist without a referral from their PCP. Referrals for laboratory, diagnostic tests and others shall be governed by that established in paragraph number two (2) of this referral section. 4. No referral is required for services related to pathological laboratories. 5. MAOs (Medicare Advantage Organizations) should inform and train all providers about the referral procedures and ensure that they understand the process to guarantee health care coordination between primary care provider and specialists. For more information, contact the Health Department's Medicaid Program. See Chapter 2, Section 6 for contact information.	
Monthly Premium	• $0 per month
Inpatient Hospital Services • **Admissions** • ***Nursery*** Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year). Coverage includes:	• $0 copay • $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
• Isolation room for medical reasons. • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized. • Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy. Blood: Blood, plasma and their derivatives without limitations, to include irradiated and antilogous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated Complex (Autoflex and Feiba) per authorization of a certified hematologist.	
Inpatient Hospital for Mental Health Diseases Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year).	• $0 copay
Inpatient Substance Use Disorder Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year).	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Outpatient Substance Use Disorder Coverage begins on the first day of Medicare, and Platino Wrap Around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year.	• $0 copay
Outpatient Mental Healthcare and Professional Services All mental health related OPD (outpatient department) services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.	• $0 copay
Laboratory and High-Tech Laboratories Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the MAO supplementary benefits but included in the State Plan.	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Family Planning Family planning services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: • Education and counseling; • Pregnancy testing; • Infertility assessment; • Sterilization services in accordance with 42 CFR 441.200 subpart F; • Laboratory services; • Cost and insertion/removal of non-oral products, such as long-acting reversible contraceptives (LARC); • At least one of every class and category of FDA-approved contraceptive; • At least one of every class and category of FDA-approved contraceptive method; and • Other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Prior Authorization or through an exception process and the prescribing Provider can demonstrate at least one of the following situations: ○ Contra-indication with drugs that the enrollee is already taking, and no other methods covered/available that can be used by the Enrollee. ○ History of adverse reaction by the Enrollee to the contraceptive methods covered ○ History of adverse reaction by the Enrollee to the contraceptive medications that are covered.	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Tobacco Cessation Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and nonprescription aids as indicated by a physician.	• $0 copay
Maternity Services Maternity services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Abortions when the pregnancy is a result of rape or incest, as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.	• $0 copay
Medical and Surgical Medical and surgical services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of Enrollee's written consent by completing the Sterilization Consent Form.	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Vision Services Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Eyeglasses or lenses for beneficiaries between the ages of 0-20 years when **medically necessary** will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months. All types of lens have to be preauthorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.	• $0 copay
Dental Services, Preventive and Restorative • Preventive (child) • Preventive (adult) • Restorative Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. The following are the benefits included in the GHP: • All preventative and corrective services for children under age twenty-one (21); • Pediatric Pulp Therapy (Pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a Pediatric Pulpotomy; • Preventive dental services for Adults; • Restorative dental services for Adults; • One (1) comprehensive oral exam per year; • One (1) periodical exam every six months; • One (1) defined problem-limited oral exam; • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography;	• $0 copay • $0 copay • $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
• Up to five (5) additional periapical/intra-oral radiographies per year; • One (1) single film-bite radiography per year; • One (1) two-film bite radiography per year; • One (1) panoramic radiography every three (3) years; • One (1) adult cleanse every six (6) months; • One (1) child cleanse every six (6) months; • One (1) topical fluoride application every six (6) months for Enrollees under nineteen (19) years old; • Fissure sealants for life for Enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when Medically Necessary because of cavity tendencies; • Amalgam restoration; • Resin restorations; • Root Canal; • Palliative treatment; • Oral Surgery; • Sedation and anesthesia services for beneficiaries with physical or mental handicaps in compliance with local laws; • Periodontal Scaling and root planning up to 4 cuadrants per beneficiary; • Interim removable partial dentures (upper and lower); • Hospital visits; • All limitations may be exceeded based on medical necessity and approved thorough prior pre authorization or exemption process.	
Hearing Exams Hearing-related services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Hearing aids for beneficiaries over 20 years old are excluded from coverage.	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Preventive Services Immunization services non-covered by: 1. Medicare Part B 2. MAO Part D drug formulary 3. MAO supplementary plan benefits 4. Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan. **Vaccines for children from 0-20 years of age (inclusive)** • Hepatitis A • Hepatitis B • Rotavirus (RV) • DTaP (Diphtheria toxoids and acellular pertussis vaccine) • Hib (Hib conjugate vaccine) • PCV 15, PCV13, and PPSV23 (Anti-Pneumococcal vaccines): Child and Adolescent Immunization Schedule Changes for 2023. CDC. • Polio (IPV) • [2]Vaccines against influenza (attenuated virus LAIV or IIV) • MMR • Varicella (VAR) • Anti-Meningococcal vaccines - MenACWY-D [Menactra], MenACWY-CRM (Menveo). The MenACWY note was updated to include language stating the newly licensed Menveo® one-vial (all liquid) formulation should not be administered before age 10 years. MenB (meningococcal serogroup B MenB-4C [Bexserol] and MenB-FHbp [Trumenba] • Tdap • Human Papillomavirus (HPV) • Dengvaxia (Indicated for the prevention of dengue disease caused by dengue virus serotypes 1, 2, 3 and 4 is approved for use in individuals 9 through 16 years of age with laboratory-confirmed previous dengue infection and living	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
in endemic areas. The Dengue note was **revised** to clarify that the dengue vaccine is recommended for seropositive children living in endemic areas, **not for children traveling to or visiting endemic dengue areas**. • **COVID 19**: Added new abbreviations for the COVID-19 vaccine products. These abbreviations contain information on the vaccine's valency (i.e., monovalent versus bivalent, indicated by "**1v**" and "**2v**," respectively) and vaccine platform (**mRNA** versus acellular protein subunit, or "**aPS**") **Vaccines for adults from 21 years of age** • Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) • Tetanus-Diphtheria Toxoids (Td) • Meningococcal conjugate A, C, W, Y or MenACWY vaccines (MenACWY-D, MenACWY-CRM, MenACWY-TT) • Meningococcal Group B Vaccine (MenB-4C, MenB-FHbp) • Measles, Mumps, and Rubella Virus Vaccine Live (MMR) • Varicella Virus Vaccine Live (VAR) • Zoster Vaccine Recombinant, Adjuvanted (RZV) • Human Papillomavirus 9-valent Vaccine, Recombinant (HPV) • Pneumococcal 15-valent Conjugate Vaccine (PCV15) • Pneumococcal 20-valent Conjugate Vaccine (PCV20) • Pneumococcal vaccine polyvalent (PCV23) • Hepatitis A vaccine, inactivated (HepA) • Hepatitis B vaccine (Recombinant) (HepB) • Hepatitis A inactivated & hepatitis B (recombinant) vaccine (HepA-HepB) • Haemophilus influenzae type b vaccine (Hib) • Influenza Vaccine: Influenza vaccine (inactivated) IIV4 or Quadrivalent Influenza vaccine (recombinant) RIV4 (Influenza vaccine (live, attenuated) LAIV4	

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
COVID 19 Vaccine - not included in the Medicaid Wrap Around but provided by the Department of Health (DOH). MAO must follow the instructions provided by CMS.	
Physical, Respiratory, Occupational and Speech Therapy Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.	• $0 copay
Emergency Room (ER) Services • **Emergency room (ER) visit** • **Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)** • **Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)** • **Trauma**	• $0 copay • $0 copay • $0 copay • $0 copay
Ambulatory Visits to • **Primary Care Physician (PCP)** • **Specialists** • **Subspecialists** • **Pre-natal Services**	• $0 copay • $0 copay • $0 copay • $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Special Coverage Special Coverage includes services related to: • HIV/AIDS • Tuberculosis • Leprosy • Systemic Lupus Erythematosus (SLE) • Cystic Fibrosis • Cancer • Hemophilia • ESRD - Levels 3, 4 and 5 • Multiple Sclerosis • Scleroderma • Pulmonary Hypertension • Aplastic Anemia • Rheumatoid Arthritis • Autism • Skin cancer • Skin cancer: carcinoma IN SITU • Skin cancer: Invasive Melanoma or squamous cells with evidence of metastasis • Adults with Phenylketonuria • Chronic Hepatitis C • Congestive Heart Failure (CHF), Class III and IV, New York Heart Association (NYHA) in a potential candidate for heart transplant • Primary Ciliary Diskinecia (PCD) • Inflammatory Bowel Disease (IBD): Crohn’s disease; Ulcerative Colitis and Microscopic Colitis • Homebound - If you are homebound, because your health condition does not allow you to leave your home unaided, or leaving the home is not medically recommended, or it involves considerable effort. You must be enrolled in the MCS Classicare Special Conditions Registry and must complete the application titled "Checklist - Homebound Criteria". Applications will be evaluated by a qualified health professional approved by MCS Classicare. Please refer to section 2.3 for details.	• $0 copay

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
Other Services • **High-tech laboratories*** • **Clinical laboratories*** • **X-Rays*** • **Special diagnostic tests*** ***Apply to diagnostics tests only. Copays do not apply to tests required as part of a preventive service.** • **Healthy child care** • **Physical Exam** • **Ambulatory Surgery**	• $0 copay • $0 copay • $0 copay • $0 copay • $0 copay • $0 copay • $0 copay
Prescription Drugs* • **Preferred (Children 0-20 years of age)** • **Preferred (Adults)** • **Non-Preferred (Children 0-20 years of age)** • **Non-Preferred (Adults)** • **Outpatient Substance Abuse** * For more information, see Chapter 6, Sections 5.2 and 5.4 of this Evidence of Coverage. Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, coinsurances or coverage gaps exceeding the State plan. The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings: • All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution. • Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for	**$0** copay for all covered drugs in all tiers of our drug formulary. Cost-sharing may change at out-of-network pharmacies. For more information please call us or see Chapter 6, Section 5.2 of this Evidence of Coverage.

Services that are covered for you	What you must pay when you get these services - Coverage Codes 100, 110, 120 and 130
possible approval of non-covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category. • Wrap Around drugs to be considered need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.	
1. The following Medicaid/CHIP Beneficiaries* are exempt of copays independent of their coverage code: • Children from 0 to less than 21 years of age (0-20 years, inclusive) • Pregnant women (during pregnancy and the 60-day post-partum period); • American Indians and Alaskan Natives (AI/AN) • Institutionalized Individuals; and • Individuals receiving hospice care. 2. Medicaid/CHIP* Beneficiaries are exempt of copays when receiving any of the following services: • Emergency services, including ambulatory, hospital, and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a); • Family planning services and supplies; • Preventative services provided to children less than 18 years of age (0- 17 years, inclusive) • Pregnancy-related services and counseling, and drugs for cessation of tobacco use; • Provider-preventable services as defined in 42 CFR 447.26(b); 3. No copay for services provided by a Preferred Network Participating Provider. Pharmacies and dentists are not part of the Preferred Provider Network. 4. Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.	

NOTE: Authorization and referrals requirements mentioned in the *Medical Benefits Chart* are also applicable for the *Benefits Covered by the Health Department's Medicaid Program* section. Referrals do not apply to conditions under Special Coverage once you are registered. Refer to Chapter 3, Section 2.2 for exceptions and important information about referrals.

SECTION 3 What services are covered outside of MCS Classicare Platino Total (HMO D-SNP)?

Section 3.1 Services *not* covered by MCS Classicare Platino Total (HMO D-SNP)

The following services are not covered by MCS Classicare Platino Total (HMO D-SNP) but are available through Medicaid:

- Family Planning
- Preventive Dental Services

As a member of MCS Classicare Platino Total (HMO D-SNP) you are covered for the benefits mentioned in Section 2.1 of this chapter, according to the established requirements and limitations, regardless of whether your benefits are provided by Medicare or Medicaid.

SECTION 4 What services are not covered by the plan?

Section 4.1 Services *not* covered by the plan (exclusions)

This section tells you what services are excluded.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined Original Medicare to not be generally accepted by the medical community.		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home	**Not covered under any condition**	
Home-delivered meals	**Not covered under any condition**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		Home Assistance, a Special Supplemental Benefit, includes preventive home cleaning/disinfection services.
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition**	
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	**Not covered under any condition**	
Private room in a hospital		• Covered only when medically necessary.
Radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	
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**	
Out-of-network services.		Please refer to exceptions described in Chapter 3, Sections 1.2 and 2.4.

CHAPTER 5:

Using the plan's coverage for Part D prescription drugs

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.**

SECTION 1 Introduction

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

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List includes Medicaid drugs covered by our plan.

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

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

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

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Providers and Pharmacies Directory*, visit our website (www.mcsclassicare.com), and/or call our Call Center.

You may go to any of our network pharmacies.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from our Call Center or use the *Providers and Pharmacies Directory*. You can also find information on our website at www.mcsclassicare.com.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact our Call Center.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note**: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Providers and Pharmacies Directory* or call our Call Center.

Section 2.3 Using the plan's mail-order service

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

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

To get order forms and information about filling your prescriptions by mail call our Call Center. You must use a mail order pharmacy from our pharmacy network; otherwise your prescription drugs will not be covered.

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. If you need an immediate supply, please call our Call Center at the numbers mentioned on the back cover of this document; or you may request a 30-day supply from your physician. Please explain to your pharmacist what happened and have them call our Call Center for an authorization.

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

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

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

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

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

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

Your prescription may be covered in certain situations

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

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

- In special circumstances, including illness, emergency, urgency or loss of prescription drugs while traveling outside of our plan's service area where there is no network pharmacy.
- Please note: The Part D drugs will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation or who does not have a valid record of opting-out of Medicare.

How do you ask for reimbursement from the plan?

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

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

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

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

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

The "Drug List" includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. The Drug List includes Medicaid drugs covered by our plan.

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

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

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

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

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

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

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more

information about this, see Section 7.1 in this chapter).

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

Section 3.2 How can you find out if a specific drug is on the "Drug List?"

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically.
2. Visit the plan's website (www.mcsclassicare.com). The "Drug List" on the website is always the most current.
3. Call our Call Center to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (https://mcs.elixirsolutions.com or by calling Call Center). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition. Members must register using an email address and create a username and password.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

Section 4.2 What kinds of restrictions?

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

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

the restriction for you. (See Chapter 9)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the

brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.

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

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

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

You may be able to get a temporary supply

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

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

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

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those who have a level of care change:** If you have a level of care change (for example, you were discharged from the hospital to your home), we will cover a temporary 31-day supply (unless you have a prescription written for fewer days). If you need a drug that is not on our formulary or, if

your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For questions about a temporary supply, call our Call Center.

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

1) You can change to another drug

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

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

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

- **Add or remove drugs from the "Drug List."**
- **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 the plan's "Drug List."

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

Information on changes to drug coverage

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

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

- **A new generic drug replaces a brand name drug on the "Drug List" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our "Drug List" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List," but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
    - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.
- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List." If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - For these changes, we must give you at least 30 days' advance notice of the change or give you

notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.

- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

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

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

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

- We put a new restriction on the use of your drug.
- We remove your drug from the "Drug List."

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

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

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are **excluded**. This means neither Medicare nor Medicaid pays for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

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

In addition, by law, the following categories of drugs listed below are not covered by Medicare or Medicaid.

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

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

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for your covered prescription drug.

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

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

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

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

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

Special note about creditable coverage:

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

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

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare

plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

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

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

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

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

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

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive

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

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

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

CHAPTER 6:

What you pay for your Part D prescription drugs

How can you get information about your drug costs if you're receiving "Extra Help" with your Part D prescription drug costs?

Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.**

SECTION 1 Introduction

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

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

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.2), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Call Center.

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

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

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

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

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

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

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered

drugs, and you followed the rules for drug coverage that are explained in Chapter 5):

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

It matters who pays:

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

Moving on to the Catastrophic Coverage Stage:

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

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

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

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health

programs such as TRICARE and Veterans Affairs.

- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

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

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for MCS Classicare Platino Total (HMO D-SNP) members?

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

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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

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

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get

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

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

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

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

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

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

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

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

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

SECTION 4 There is no deductible for MCS Classicare Platino Total (HMO D-SNP)

There is no deductible for MCS Classicare Platino Total (HMO D-SNP). You begin in the Initial Coverage Stage when you fill your first prescription for the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

Your pharmacy choices

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

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

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

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

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

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

	Standard retail cost sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing for Covered Drugs	$0 copayment	$0 copayment	$0 copayment
**** Out-of-network:*** *You pay the difference between the in-network cost and the out-of-network cost for covered prescription drugs received from a non-network pharmacy.*			

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

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

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

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

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

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

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

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

	Standard retail cost-sharing (in-network) (up to a 60-day and up to a 90-day supply)	**Mail-order cost-sharing** (up to a 90-day supply)
Cost-Sharing for Covered Drugs	$0 copayment	$0 copayment
*Not all drugs are available for extended supply. These drugs are marked as "**NeDS**" in our Drug Formulary.* *In order to provide you and your doctor with an opportunity to properly assess the effectiveness of a drug, only the first prescription fill will be covered for 30 days for some of the drugs available for a long-term supply. These drugs are marked as "**FFQL**" in our Drug Formulary.*		

A long-term supply is not available for specialty drugs.

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

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

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

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

SECTION 6 Costs in the Coverage Gap Stage

During the Coverage Gap Stage, we will continue to provide prescription drug coverage until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach the amount of $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

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

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most

adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won't pay more than $0 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

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

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

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

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

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List". Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug List" or contact our Call Center for coverage and cost-sharing details about specific vaccines.

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

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

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

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

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

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

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

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

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

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

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

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid.

CHAPTER 7:

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

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for a Medicare service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

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

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

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

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

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you

to pay more than your share of the cost.

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

3. If you are retroactively enrolled in our plan

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

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

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

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

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

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

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

When you send us a request for payment, we will 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 will 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 of this document has information about how to make an appeal.

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

You may request us to pay you back by either calling us or 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 365 days of the date you received the service, item, or Part B drug.

You must submit your Part D (prescription drug) claim to us within 180 days of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster. You will need to specify your name, your member ID#, your address, the date of service or fill, your provider, etc.
- Either download a copy of the form from our website www.mcsclassicare.com or call our Call Center and ask for the form.

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

Payment Request for Medical Care
MCS Advantage, Inc. – Claims Department
PO BOX 191720
San Juan, PR 00919-1720

Payment Request for Part D Prescription Drugs
MCS Advantage, Inc. – Pharmacy Department
PO BOX 191720
San Juan, PR 00919-1720

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

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

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

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

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

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

CHAPTER 8:

Your rights and responsibilities

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

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

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

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

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, getting access to a women's health specialist, or access to other specialists within the network, please call to file a grievance with our Call Center at 787-620-2530 (Metro Area), 1-866-627-8183 (Toll Free) (TTY users should call 1-866-627-8182) Monday through Sunday from 8:00 a.m. to 8:00 p.m. (from October 1 to March 31) and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. (from April 1 to September 30.). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Debemos proporcionarle información de una manera que sea conveniente para usted y sus sensibilidades interculturales (en otros idiomas que no sean español, en braille, en tamaño de letra grande, audio CD u otros formatos alternativos, etc.)

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del español, habilidades limitadas de lectura, discapacidad auditiva o aquellos con antecedentes

culturales y étnicos diversos. Los ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la disposición de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder a las preguntas de los miembros que no hablan español. Esta información se encuentra disponible gratis en inglés. También podemos proporcionarle información en braille, en tamaño de letra grande, audio CD o en otros formatos alternativos, sin costo alguno, si lo necesita. Debemos proporcionarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información sobre nosotros de una manera que sea conveniente para usted, llame a nuestro Centro de Llamadas.

Nuestro plan debe brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para servicios de atención médica preventiva y de rutina para mujeres.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan ubicar proveedores especializados fuera de la red que le brindarán la atención necesaria. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde acudir para obtener este servicio con costos compartidos dentro de la red.

Si tiene alguna dificultad para obtener información sobre nuestro plan en un formato que sea accesible y adecuado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llámenos para presentar un reclamo ante nuestro Centro de Llamadas al 787-620-2530 (Área Metropolitana), 1-866-627-8183 (libre de cargos), 1-866-627-8182 (usuarios de TTY); lunes a domingo de 8:00 a.m. a 8:00 p.m. (del 1 de octubre al 31 de marzo) y de 8:00 a.m. a 8:00 p.m. de lunes a viernes y sábado de 8:00 a.m. a 4:30 p.m. (del 1 de abril al 30 de septiembre). También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 ó TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call our Call Center.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MIGHT BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THE SAME. PLEASE, REVIEW IT CAREFULLY

OUR LEGAL RESPONSIBILITY

MCS is committed to safeguarding your Protected Health Information (PHI). We are required by Law to maintain the privacy, security, and confidentiality of your PHI, to provide you with this Notice of our legal duties and privacy practices with respect to PHI, and to inform affected individuals following a reportable breach of unsecured PHI.

MCS is required to abide by the terms of this Notice. However, we reserve the right to change or modify the terms of this Notice, and to make the provisions in our revised Notice effective for all PHI that we maintain. In the event, the terms of this Notice are revised, we will post a copy of the amended Notice in our Internet site, and will mail a printed copy of this document to our subscribers by its effective date. Any type of information that MCS can collect and/or disclose, and that is considered non-public financial personal information, as defined in Regulation Number 75 of the Office of the Commonwealth of Puerto Rico's Insurance Commissioner, will also be considered as PHI, as defined in 45 CFR Part 164, Section 164.501, and Chapter 14 – Protection of Health Information of the Puerto Rico Health Insurance Code – 26 L.P.R.A. 9231 et al., as amended.

PHI is information that can identify you (name, last name, social security number); including demographic information (like address, zip code), obtained from you through a request or other document in order to obtain a service, created and received by a health care provider, a medical plan, intermediaries who submit claims for medical services, business associates, and that is related to (1) your health, past, present, or future physical or mental conditions; (2) the provision of medical care to you, or (3) past, present, or future payments for the provision of such medical care. For purposes of this Notice, this information will be called PHI. This Notice of Privacy Practices has been written and amended, so that it will comply with the HIPAA Privacy Regulation. Any term not defined in this Notice will hold the same meaning as in the HIPAA Privacy Regulation. We have also implemented policies and procedures to handle PHI, which you may examine at your request.

MAIN USES AND DISCLOSURES OF PHI

MCS may use and disclose PHI for the following purposes:

Treatment: For the provision, coordination, or supervision of your medical care, and other related services. For example, the plan may disclose medical information to your health care provider for treatment, if so requested.

Payment: To collect or provide payment for medical care, including collections and claims handling. For example, the plan may use or disclose PHI in order to pay claims for health services rendered, or to provide eligibility information to your health care provider when you receive treatment.

Health care operations: To support our business functions. For example, for legal and audit processes, fraud and abuse detection, compliance, business planning and development, administrative activities, and businesses management. The plan might use or disclose your protected Health information (PHI) to provide you with appointment or meeting reminders, information about treatment alternatives or other health related benefits and services. Also, we may disclose your health information to the sponsor of a health plan, in accordance with Section 164.504(f) of the Privacy Regulation. However, MCS is prohibited from using or disclosing PHI that is genetic information for underwriting related activities, in accordance with Section

164.520(b)(1)(iii) of the Privacy Regulation.

Covered Entities

In order to perform our duties as insurance or benefit administrator, we may use or disclose PHI among the following entities: MCS Healthcare Holdings, LLC., MCS Life Insurance Company, and MCS Advantage, Inc.

Business Associates

We contract with persons and organizations (business associates) so they can perform certain functions in our name, or to provide certain types of services. Business associates may receive, create, maintain, use, or disclose PHI, but only after they agree in writing to properly safeguard such information.

Third Party Apps

Third-Party App are not subject to the HIPAA Rules and other privacy laws, which generally protect your health information. Instead, Third-Party App's privacy policy describes self-imposed limitations on how the App will use, disclose, and (possibly) sell information about you.

OTHER POSSIBLE USES AND/OR DISCLOSURES OF YOUR PHI

Required by Law

We may use or disclose your PHI whenever Federal, State, or Local Laws require its use or disclosure. In this Notice, the term "as required by Law" is defined in the same as it is in the HIPAA Privacy regulation.

Public health activities

We may use or disclose your PHI for public health activities, including the statistical report on illnesses and vital information, among others.

Health oversight activities

We may use or disclose your PHI to government agencies that regulate health care related activities.

Food and Drug Administration (FDA)

We may use or disclose your PHI to the FDA in order to prevent an imminent threat to the health or national security in relation to adverse events involving food, supplements, products and product defects, among others.

Abuse or neglect

We may use or disclose your PHI to a government official authorized to receive reports of abuse or neglect against minors or adults or domestic violence situations.

Legal proceedings

We may use or disclose your PHI during the course of any judicial or administrative proceedings: (1) in response to an order from a court or administrative agency (provided that the covered entity discloses only

the PHI expressly specified by such order); or (2) in response to a subpoena, discovery request, or other lawful process.

Law enforcement officials

We may use or disclose your PHI to law enforcement officials. For example, we may provide information necessary to report a crime, or to locate or identify a suspect, a fugitive, material witness or missing person, or necessary to provide evidence of a crime committed on our premises.

Medical examiners, funeral directors, and organ donation cases

We may use or disclose your PHI to a medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. We may also disclose your information to a funeral director, as necessary to carry out its duties with respect to a decedent and to other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

Research

We may use or disclose your PHI for research purposes, if an Institutional Review Board or an Ethics Committee: (1) has reviewed the research proposal and has established protocols to protect your information's confidentiality, and (2) has approved the research as part of a limited data set, which does not include individual identifiers.

To avert a serious threat to health or safety

We may use or disclose your PHI in order to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Correctional institutions

We may disclose PHI to a correctional institution or a law enforcement official having lawful custody of an inmate when necessary: (1) for the provision of health care to the inmate; (2) in order to protect the health and safety of the inmate or other persons, or (3) in order to protect the health and safety of the entire correctional institution.

Worker's compensation

We may use or disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Disaster relief

We may disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This way, your family may be provided with information about your health condition and your location in case of a disaster, or any other emergency.

Military activity, national security, protective services

We may disclose your PHI to appropriate military command authorities if you are a member of the Armed

Forces, or a veteran. Also, to authorized federal officials for the conduct of national security activities, lawful intelligence, counter-intelligence, or other national security and intelligence activities for the protection of the President, other authorities, and heads of state.

Other persons participating in your health care

We may disclose limited PHI to a friend or family member who is involved with your care, or who is responsible for payment of medical services. If you are not in person, if you are disabled, or it is an emergency, we will use our professional judgment in the disclosure of information that we understand will be in your better interest.

Disclosures to you

We are required to disclose to you most of your PHI. This includes, but is not limited to, all information related to your claims history.

Disclosures to an authorized representative

We will disclose your PHI to a person designated by you as your authorized representative, and who qualifies for this designation in accordance with applicable laws of the Commonwealth of Puerto Rico. However, before we disclose your PHI to your authorized representative, you must provide us with a written document designating this person as such, along with any other supporting documents (like a power of attorney or an Advanced Statement of Will Regarding Treatment). A paper form is available for this purpose through our service centers and through our Internet site.

Even when you designate an authorized representative, HIPAA Privacy Regulations allow us not to treat this person as your authorized representative if, in our professional judgment, conclude that: (1) you have been or may be subject to domestic violence, abuse, or neglect by such person; (2) treating such person as your authorized representative could endanger you, or (3) we, in the exercise of our professional judgment, decide that it is not in your best interest to consider this person as your authorized representative.

With your authorization

You may authorize us in writing to use or disclose your PHI to other persons, for any other purpose. The authorization must be signed and dated by you, it must indicate the person or entity authorized to receive the information, a short description of the information been disclosed, and expiration date for the authorization. Additionally, the following uses and disclosures require an authorization, in accordance with Section 164.508(a)(2) – (a)(4) of the Privacy Regulation: (a) For psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private or group counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. (b) For marketing activities, which involve communications about a product or service that encourage recipients of said communications to purchase or use the product or service. (c) Sale of PHI, which involves the disclosure of PHI by a covered entity or business associate in exchange for direct or indirect remuneration. You have the right to revoke the authorization in writing, in accordance with Section 164.508(b)(5) of the Privacy Regulation. The revocation will be in effect for future uses and disclosures of your PHI, but it will not apply to information that we have already used or disclosed. Unless you submit a written authorization,

we may not use or disclose your protected health information for any other reason not described in this Notice.

Disclosures to the Secretary of Health and Human Services

We are required to disclose your PHI to the Secretary of Health and Human Services, in order to determine if we are complying with HIPAA regulations.

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

Right to request a restriction

You have the right to request a restriction to certain uses and disclosures of PHI as provided in Section 164.522(a) of the Privacy Regulation. However, we are not required to agree to any restriction that you request, except in case of a disclosure restricted under Section 164.522(a)(1)(vi) of the same regulation. If we agree to a restriction, we will comply with it, unless the information is needed to provide you with emergency treatment. You may request a restriction by completing a request form, available at our service centers and through our Internet site.

Right to confidential communications

You may request that we communicate with you concerning your PHI using an alternate method or physical location. For example, you may request that we contact you only at your work address, or that of one of your relatives. You may request confidential communications by completing a request form, available at our service centers and through our Internet site.

Right to access

You have the right to inspect and copy your personal, financial, insurance, or health information, within the limits and exceptions provided by law. In order to access your information, contact our Call Center to submit your request. We will validate your identity before providing assistance. You may also visit any of our Service Centers in order to submit a written request for a copy or to review your PHI. We will provide you with access within 30 business days. We may deny access to inspect or copy your PHI under certain limited circumstances.

Right to amend

If you believe that your PHI and the information that we keep in our files and/or systems is incomplete or incorrect, you may request that we amend it. Submit a request to amend your PHI by completing a request form, available at our service centers or through our Internet site.

Right to an accounting of disclosures

You have the right to request an accounting of certain disclosures of your PHI, made by MCS, for events not related to medical treatment, payment for medical services, health care operations, or in compliance with your authorization. You may request an accounting of disclosures by completing a request form available at our service centers or through our Internet site.

Right to a printed copy of this Notice

You have the right to obtain a paper copy of this Notice of Privacy Practices at your request, even after agreeing to receive a copy in electronic form.

COMPLAINTS

You have the right to file a complaint with MCS and the Secretary of the Department of Health and Human Services (DHHS), if you believe that your privacy rights have been violated. All complaints must: (1) be filed in writing; (2) include the name of the covered entity that is the subject of the complaint; (3) describe the acts or omissions believed to be in violation of the standards, and (4) be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. We will not penalize nor retaliate against you for filing a complaint with the Secretary of DHHS, or with MCS.

MCS complies with applicable Federal civil rights laws and do not discriminate on the basis on race, color, national origin, age, disability, or sex. MCS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. MCS provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). MCS provides free language services to people whose primary language is not English, such as: qualified interpreters, and information written in other languages. If you need these services, contact our Call Center. If you believe that MCS 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: MCS Call Center, PO BOX 191720, San Juan, PR 00919-1720, 787-281-2800 (Metro Area), 1-888-758-1616 (toll free), 1-866-627-8182 (TTY users). You can file a grievance in person or by mail. If you need help filing a grievance, our Call Center 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, 800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Please be advised that most Third-Party App's will not be covered by HIPAA. Most apps will instead fall under the jurisdiction of the Federal Trade Commission (FTC) and the protections provided by the FTC Act. The FTC Act, among other things, protects against deceptive acts (e.g., if an app shares personal data without permission, despite having a privacy policy that says it will not do so). If you have any concerns regarding the use of Third-Party App's and your information you may contact the Federal Trade Commission (FTC) and file a complaint at https://reportfraud.ftc.gov/#/.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.888.758.1616 (TTY: 1.866.627.8182).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.758.1616 (TTY: 1.866.627.8182).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.758.1616（TTY:

1.866.627.8182).

CONTACT INFORMATION FOR MCS

You may request additional information about this Notice of Privacy Practices, or file a complaint with MCS at the following address:

MCS
Attention: Privacy Officer
Box 9023547
San Juan, PR 00902-3547
Telephone line for Privacy and Security
Metro Area: (787) 620-3186
Toll Free: 1-877-627-0004
mcscompliance@medicalcardsystem.com

EFFECTIVE DAY

This Notice of Privacy Practices is effective on July 1, 2021.

For the most up-to-date version of this notice please visit: www.mcsclassicare.com/en/Pages/privacy-notice.aspx.

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

As a member of MCS Classicare Platino Total (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call our Call Center:

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications and credentials of the providers and pharmacies in our network and how we pay the providers in our network.
    - Medical professionals must display in their offices their credentials (Licenses, Certificates, and Diplomas) and capabilities to allow patients to make informed choices about their health care.
    - All providers must display their Malpractice Coverage Certificate so that their patients can easily read it. The information is also available upon request. Contact the plan for details.
    - If a provider does not have the Malpractice Coverage Certificate, he or she must inform and display such information in a prominent location in his or her office.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

Advance Directives Requirements in Puerto Rico:

Every person of legal age (21 years old and over), capable for all legal purposes, has the right to declare its desire or will with respect to its medical treatment. Pursuant to Puerto Rico law (Act. 160-2001). Every person interested in giving advance directives must prepare a statement complying with the following requirements:

- Be in writing, signed and sworn in the presence of a notary public.
- In the alternative, the declarant may make the statement in the presence of a physician and two competent witnesses, who are not heirs of the declarant, and who do not participate in the direct care of the patient.
- Declare in the statement the voluntary nature of the directives.
- Must include the date, time, and place where the directives are executed.

The document can also express any other orders relating to medical care that will be professionally evaluated by the doctors in charge of the person's treatment. It can include the designation of someone to make decisions for you regarding the acceptance or rejection of treatment, in the event you are unable to

communicate on your own behalf.

You also must provide a copy of the advanced directives to your physician, or to the institution providing your health care services. Keep in mind that you must comply with all the requirements established by Law in order to the advance directives be legally binding. Therefore, your advance directives regarding your medical treatment must specify that they were voluntarily provided, indicate the date, time and place where the statement was executed, and signed and sworn before a notary public, or made before a physician and two witnesses, as previously indicated.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Puerto Rico Office of the Patient's Advocate, PO Box 11247, San Juan PR 00910-2347. You may contact them at 787-977-0909 and 1-800-981-0031, or www.opp.pr.gov for more information.

You may also file a grievance related to Advance Directives with The Puerto Rico Health Insurance Administration (ASES, by its Spanish acronym). Please see Chapter 2, Section 6 for contact information. Or you may also file a grievance to Advance Directives with the Office of the Patient's Advocate at the contact information presented in Section 1.6 of this Chapter.

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

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

You can also file a grievance with the Puerto Rico Office of the Patient's Advocate by calling: (787) 977-0909; 1-800-981-0031 (Toll Free); TTY: (787) 710-7057.

You may also write to the following address: PO Box 11247, San Juan, P.R. 00910-2347. The Puerto Rico Office of the Patient's Advocate website is: http://www.opp.pr.gov/. Their email is: info@opp.pr.gov.

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

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

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about

discrimination, you can get help dealing with the problem you are having:

- You can **call our Call Center**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call our Call Center**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections.* (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call our Call Center.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

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

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- 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.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "integrated organization determination" or "coverage determination" or "at-risk determination," and "independent review organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to our Call Center for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you

more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website (www.medicare.gov).

You can get help and information from Medicaid

You can get help and information from Puerto Rico Medicaid.

- You can call 787-641-4224. Monday through Friday from 8:00 a.m. to 6:00 p.m.
- You can visit their website (https://www.medicaid.pr.gov/).
- You can use TTY/TDD 787-625-6955. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
- You can write to them at:

  Medicaid Program - Puerto Rico Department of Health
  PO BOX 70184
  San Juan, PR 00936-8184

  prmedicaid@salud.pr.gov

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from Medicaid. Information in this chapter applies to **all** of your Medicare and Medicaid benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, “Step-by-step: How a Level 2 appeal is done.”

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid.**

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 5, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 11** at the end of this chapter, **"How to make a complaint about quality of care, waiting times, customer service, or other concerns."**

SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical care or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can "**appeal**" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "f**ast appeal**" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See Section 6.4 of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at our Call Center**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call our Call Center and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.mcsclassicare.com.)
    - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call our Call Center and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.mcsclassicare.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter, “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter, “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter, “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, call our Call Center. You can also get help or information from government organizations such as your SHIP.

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

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

facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

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

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 6.3 Step-by-Step: How to make a Level 1 Appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

A "standard appeal" is usually made within 30 days or 7 days for Part B drugs. A "fast appeal" is

generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should **not** take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**

- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 Step-by-step: How a Level 2 appeal is done

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

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

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 186 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called

your "case file." **You have the right to ask us for a free copy of your case file.**

- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

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

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

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

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

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

- **If the 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 receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests.**
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved.

(This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: You can ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.
  - As a plan member, some of your plan services may also be covered by Medicaid. Therefore, you have the right to file an appeal if you believe that we improperly denied you a service or payment for a service before the Government Health Plan (GHP). Also, you have the right to appeal a grievance determination. We will let you know in writing if you have the right to appeal our decision to Medicaid.
  - You or a representative authorized by you may request an Administrative Law Hearing before GHP, within 120 days from receipt of the determination of the plan. To request an Administrative Law Hearing before GHP must do so in writing to the following address:

    Executive Director
    Government Health Plan
    PO BOX 195661
    San Juan, Puerto Rico 00919-5661

- You must indicate your name, address, member number, name of the provider or health care organization where you received or will receive the service under appeal, a brief description of the claim or situation why you are requesting the hearing, and send a copy of the final decision issued by the plan. May include any evidence useful, such as, medical records, doctor' letters, or other information that explains why you need the item or service. GHP will make a decision within ninety (90) days from the date on which you settled that appeal to the plan (the GHP will

exclude the days it took you to request your hearing before GHP). In the event that the appeal to the plan has been expedited, GHP will make a decision at the hearing on or before three (3) business days from the date of the receipt of the request for a hearing in GHP for a denied service that meets criteria to be considered in an expedited appeal process, but that was not resolved by the plan in terms of the time set for expedited appeals, or was totally or partially resolved in a not favorable manner to you in those terms.

- The decision reached by GHP is appealable before the court of appeals of the Commonwealth of Puerto Rico.
- If GHP reverses MCS Classicare's initial determination:
    - MCS Classicare authorizes the provision of the disputed services as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date MCS Classicare receives notice reversing the determination.
    - MCS Classicare pays for the disputed services when the member received the disputed services while the appeal was pending.
- During the period in which your case is evaluated, you may ask continuity in the services subject to the appeal to the plan. To do this, you must complete a form for requesting service continuity on appeal. The form will be available upon request at the MCS Classicare Call Center. If the decision to deny the MCS Classicare appeal is maintained by GHP, you may be responsible for paying the cost of services or benefits you received while the appeal process was pending. In this case, the plan reserves the right to recover such costs from you. MCS Classicare continues your benefit during the appeal process if:
    - The appeal is filed timely, i.e., on or before the intended effective date of the plan's proposed action; or within 10 days of the postmarked date on the notice mailed to you, whichever happens last.
    - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
    - The services were ordered by an authorized provider;
    - The authorization period has not expired; and you request extension of benefits.
- If MCS Classicare continues or reinstates your benefits while the appeal is pending, the benefits shall be continued until one of following occurs:
    - You withdraw the appeal;
    - You do not request an Administrative Law Hearing within 10 days from when we mail you an adverse decision;
    - The GHP's Administrative Law Hearing decision is adverse to you; or
    - The authorization expires or the authorized service limits are met.

- The enrollee must first exhaust our plan's Grievance and Appeal System before accessing the Administrative Law Hearing process.

MCS Classicare may recover the cost of the continuation of services furnished to you while the appeal was pending if the final resolution by GHP upholds MCS Classicare's initial decision.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5 What if you are asking us to pay you back for our share of a bill you have received for medical care?

If you have already paid for a Medicaid service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us.

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

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you

followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

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

- We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the health care provider within 60 calendar days.

SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's List of Covered Drugs. **Ask for an exception**. **Section 7.2**.
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception**. **Section 7.2**.
- Asking to get pre-approval for a drug. **Ask for a coverage decision**.**Section 7.4**.
- Pay for a prescription drug you already bought. **Ask us to pay you back**. **Section 7.4**.

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

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

Section 7.2 What is an exception?

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

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

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

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the "Drug List," you will need to pay the cost-sharing amount that applies to drugs in tier five (5) – specialty drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay

for the drug.

2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

We can say yes or no to your request

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

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

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

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

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

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

- You must be asking for a *drug you have not yet received.* (You cannot ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which are available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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

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

Deadlines for a "fast coverage decision"

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

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 7.5 Step-by-step: How to make a Level 1 appeal

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

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

A "standard appeal" is usually made within 7 days. A "fast appeal" is generally made within 72

hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 7.4 of this chapter.

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

- **For standard appeals, submit a written request**, or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 787-620-2530 (Metro Area), 1-866-627-8183. Calls to this number are free**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 7.6 Step-by-step: How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for "fast appeal"

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

Deadlines for "standard appeal"

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

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

For "fast appeals":

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

For "standard appeals":

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

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

What if the review organization says no to your appeal?

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call our Call Center or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call our Call Center or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need

to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call our Call Center. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
    - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
    - If you do **not** meet this deadline and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling our Call Center or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

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

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter talks more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

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

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

Step-by-Step: How to make a Level 1 Alternate appeal

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

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

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital **after** your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say no to your appeal, your case will automatically be sent on to the next

level of the appeals process.

Step-by-Step: Level 2 Alternate appeal Process

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

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

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

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.

- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** *for your care*.

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

Section 9.2 We will tell you in advance when your coverage will be ending

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

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

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals

process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call our Call Center. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see **Section 9.5** of this chapter.

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and

review information that our plan has given to them.

- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

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

Step-by-Step: How to make a Level 1 Alternate appeal

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

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 Alternate appeal Process

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

Medicare to handle the job of being the independent review organization. Medicare oversees its work.

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

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. **Section 11** of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

make a Level 3 appeal.

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

Level 3 Appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

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

Level 4 appeal	The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

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

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

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

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

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

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

Level 3 appeal	**An Administrative Law Judge or attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Call Center? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Call Center or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Complaint	Example
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 have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

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

Section 11.3 Step-by-step: Making a complaint

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

- **Usually, calling our Call Center is the first step.** If there is anything else you need to do, our Call Center will let you know.

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- Here's how it works:
  - You may file a grievance by visiting the service center nearest to your location, sending it by fax at: 787-620-7765; or by mail at: MCS Advantage, Inc., Grievances and Appeals Unit, P.O. Box 195429, San Juan, PR 00919-5429. You may use the MCS Classicare Grievance Submission Form to submit your grievance, however, its use is not mandatory.
  - We will provide you with a response as expeditiously as your health status requires but no later than 30 calendar days from the day of receipt unless extended. If the plan grants itself a 14-day extension of the time frame it will notify you in writing.
  - You have the right to file an expedited (fast) grievance if we extend the timeframe to make a coverage decision. You may also file an expedited grievance if we refuse to grant you a request for an expedited coverage decision or appeal. When you request an expedited grievance, we will provide you with a response within 24 hours. If you would like to file an expedited grievance you may call us.
  - Either you or your authorized representative may file a grievance. The person you name will act as your "representative." It may be a relative, a friend, a lawyer, a doctor, or any other person or provider you choose to act on your behalf. There may be someone who is already legally authorized to act as your authorized representative under State law. If you wish for someone in particular to act on your behalf, but that person has not yet been authorized by the Court or State law, call our Call Center and ask for the form to give that person permission to legally act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf.
- **Whether you call or write, you should contact our Call Center right away.** You can make the complaint at any time after you had the problem you want to complain about.

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

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

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

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about MCS Classicare Platino Total (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

You or a representative authorized by you may request an Administrative Law Hearing before GHP, within 120 days from receipt of the determination of the plan. To request an Administrative Law Hearing before GHP must do so in writing to the following address:

Executive Director
Government Health Plan
PO BOX 195661
San Juan, Puerto Rico 00919-5661

CHAPTER 10:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MCS Classicare Platino Total (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
  - Another Medicare health plan, with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

    Contact your State Medicaid Office to learn about your Medicaid plan options (telephone

numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the Annual Open Enrollment Period). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

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

    OR

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

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

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

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

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

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

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

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

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

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

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

received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call our Call Center**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from MCS Classicare Platino Total (HMO D-SNP) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from MCS Classicare Platino Total (HMO D-SNP) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan • If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. • If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll**. Contact our Call Center if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from MCS Classicare Platino Total (HMO D-SNP) when your coverage in Original Medicare begins.

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

For questions about your Medicaid Program benefits, contact the Puerto Rico Department of Health - Medicaid Program at 787-641-4224 (toll free) Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY/TDD users should call 1-787-625-6955. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid Program coverage.

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

Until your membership MCS Classicare Platino Total (HMO D-SNP) ends, and your new Medicare and Medicaid coverage begins, you must continue to get your medical items, services, and prescription drugs through our plan.

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

SECTION 5 MCS Classicare Platino Total (HMO D-SNP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

MCS Classicare Platino Total (HMO D-SNP) 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 are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. If during your enrollment in our plan, you lose eligibility to Medicaid, you need to do the following:
  - Call your Medicaid office immediately to request an appointment in order to be recertified and not lose your Platino benefits. If you do not recertify your Medicaid eligibility, we will keep you in our plan for six months beginning the first day of the following month we learned that you have lost your Medicaid eligibility. For more information on how to keep your Medicaid eligibility, refer to Section 6 in Chapter 2 of this booklet.
- If you do not pay your medical spend down, if applicable.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call our Call Center to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call our Call Center.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

MCS Classicare Platino Total (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at our Call Center. If you have a complaint, such as a problem with wheelchair access, our Call Center can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, MCS Classicare Platino Total (HMO D-SNP), 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 Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

MCS Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MCS Advantage, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MCS Advantage, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Grievances and Appeals Unit.

If you believe that MCS Advantage, Inc. 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: Grievances and Appeals Unit; MCS Advantage, Inc.; P.O. Box 195429, San Juan, PR, 00919-5429; 787-620-2530 (Metro Area); 1-866-627-8183 (toll free); 1-866-627-8182 (TTY users), 787-620-7765 (fax). You can file a grievance in person or by mail or fax. If you need help filing a grievance, our Grievances and Appeals Unit 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, 800-537-7697 (TDD).

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

SECTION 5 Protections When Reporting Suspicions on Fraud, Abuse and/or Waste

Under the rules of our plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation. You have the right to not be neglected, intimidated, physically or verbally abused, mistreated, or exploited. You also have the right to be treated with consideration, respect, and full recognition of your dignity, privacy, and individuality.

We cannot deny services to you or punish you for exercising your rights. Your exercising of your rights will not negatively affect the way MCS Classicare and its providers, or CMS provide or arrange for the provision of services to you.

Protections When Reporting Suspicions on Fraud, Abuse and/or Waste (“Whistleblower Protections”)

MCS complies with federal and state regulations establishing that any person and/or entity must report any

suspicion of fraud, abuse and/or waste identified against Medicare and/or Medicaid Program. In complying with federal and state regulations, MCS protects any person from any kind of retaliation who reports in good faith a suspicion of fraud, abuse and/or waste.

It is important that you report to MCS any situation in which your healthcare services are being affected or can be affected because of identifying and/or reporting any suspicion of fraud, abuse and/or waste to MCS and/or any federal and/or local agency. Suspicion of fraud, waste and/or abuse can be any service billed by a provider to MCS and/or you that was not received, among any other scheme that you consider suspicious.

Report to MCS

Remember, you may report any real or potential situation about non-compliance, financial exploitation, fraud, abuse and/or waste through our *ACTright* confidential report lines in our Web page: https://mcsclassicare.com/en/Pages/fraud-abuse.aspx; by email: mcscompliance@medicalcardsystem.com; or our Confidential line: 1-877-MCS-0004 (1-877-627-0004).

CHAPTER 12:

Definitions of important words

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of MCS Classicare Platino Total (HMO D-SNP), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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 cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

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.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

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

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings

specified in 42 CFR 422.4(a)(1)(iv).

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.

Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

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

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

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

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

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

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

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

doesn't pay for custodial care.

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

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

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual Eligible Individual – A person who qualifies 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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

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

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance. This program is not available in Puerto Rico.

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

brand name drug and usually costs less.

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

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

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

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

Independent Practice Association (IPA) – An IPA is an organization of independent doctors, or groups of primary doctors, that have contracted with health maintenance organizations to offer covered medical services. See Chapter 1, Section 6.

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

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

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

Integrated Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Integrated 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 booklet.

Interdisciplinary Team (IDT) – A group of individuals with diverse training and background that collaborate to manage beneficiary care through a comprehensive individualized care plan with beneficiary/caregiver participation in care planning, when feasible, at a central point of contact.

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

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

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for

covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

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

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

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

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

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

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

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

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

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient

prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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

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

Model of Care – The model of care is a CMS requirement that allows Medicare Advantage Organizations to coordinate and manage individualized care through the integration of services and benefits in order to satisfy each dual eligible special need member. Among the needs that we work with are: clinical, functional, psychosocial and cognitive (learning).

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."

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

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

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

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

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain

categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

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 provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. 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.

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

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

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

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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

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

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

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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

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

MCS Classicare Platino Total (HMO D-SNP) Call Center

Method	Call Center – Contact Information
CALL	1-866-627-8183 Calls to this number are free. 787-620-2530 (Metro Area) Calls to this number are *not* free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Our Call Center also has free language interpreter services available for non-English speakers.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
FAX	787-620-1337
WRITE	MCS Advantage, Inc. Call Center PO BOX 191720 San Juan, PR 00919-1720
WEBSITE	www.mcsclassicare.com

Programa Estatal de Asistencia Sobre Seguros de Salud (Puerto Rico SHIP)

Programa Estatal de Asistencia Sobre Seguros de Salud is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-877-725-4300 (San Juan Area) 1-800-981-0056 (Mayagüez Area) 1-800-981-7735 (Ponce Area)

Method	Contact Information
TTY	787-919-7291 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	State Health Insurance Assistance Program Puerto Rico Office of the Ombudsman for the Elderly P.O. Box 191179 San Juan, PR 00919-1179
WEBSITE	https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx