

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of MCS Classicare Patriot (HMO)

This document gives you the details about your Medicare health care 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 Patriot (HMO), 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 Patriot (HMO).)

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 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 benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in MCS Classicare Patriot (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, MCS Classicare Patriot (HMO). 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 Patriot (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. MCS Classicare Patriot (HMO) does not include Part D 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 medical care. 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 available to you as a member of MCS Classicare Patriot (HMO).

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 Patriot (HMO) covers your care. Other parts of this contract include your enrollment form 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 Patriot (HMO) 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 Patriot (HMO) after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Chapter 1 Getting started as a member

Medicare (the Centers for Medicare & Medicaid Services) must approve MCS Classicare Patriot (HMO) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

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

Section 2.2 Here is the plan service area for MCS Classicare Patriot (HMO)

MCS Classicare Patriot (HMO) 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 2.3 U.S. Citizen or Lawful Presence

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

Chapter 1 Getting started as a member

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

SECTION 3 Important membership materials you will receive**Section 3.1 Your plan membership card**

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

MCS Classicare <small>(HMO)</small>	
<PLAN NAME>	
Group: <85-850000>	<GN> <SN>
Plan: (80840)	<PCP> <\$X>
Contract: <XXXXXXXXXX>	<SP> <\$X>
Member: <Name>	<SUB> <\$X>
Coverage: <HX-MQX-AX-DX-V-F>	<HOSP> <\$X> <\$X>
Effectiveness: <XX/XX/XXXX>	<AMB> <\$X>
Physician: <PCP Name>	 <X%>
	<LAB> <X%> <\$X>
	<XR> <X%>
RxBIN: <XXXXXX>	RxGroup: <XXXX>
RxPCN: <XXXXXX>	CMS: H5577- <XXX>

<CALL CENTER>		
<787.620.2530>		
<Toll Free 1.866.627.8183 >		
<(TTY) Hearing impaired 1.866.627.8182>		
<Monday through Friday from 8:00 a.m. - 8:00 p.m.>		
MCS solutions 1.800.760.5691	MCS medilínea 1.866.727.6271	MCS medilíneaMD 1.833.275.6276
Send medical, dental and pharmacy claims to:		
P.O. Box 191720, San Juan, PR. 00919-1720		
<PCP: Family Physician, Internist, Generalist & Geriatrician.>		
mcsclassicare.com		Subscribed by MCS Advantage, Inc.

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 Patriot (HMO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If 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 Directory

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

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 Patriot (HMO) authorizes use of out-of-network providers.

Chapter 1 Getting started as a member

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

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

SECTION 4 Your monthly costs for MCS Classicare Patriot (HMO)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for MCS Classicare Patriot (HMO).

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

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

SECTION 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.

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).

Chapter 1 Getting started as a member

The doctors, hospitals, 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 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:

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

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

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

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

CHAPTER 2:

*Important phone numbers
and resources*

SECTION 1 MCS Classicare Patriot (HMO) 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 Patriot (HMO) 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 <i>not</i> 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 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	<p>787-620-2530 (Metro Area) Calls to this number are <i>not</i> free.</p> <p>1-866-627-8183 Calls to this number are free.</p> <p>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.</p>
TTY	<p>1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>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.</p>
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 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
CALL	<p>787-620-2530 (Metro Area) Calls to this number are <i>not</i> free.</p> <p>1-866-627-8183 Calls to this number are free.</p> <p>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.</p>
TTY	<p>1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>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.</p>
FAX	787-620-7765
WRITE	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
WEBSITE	www.mcscare.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 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	<p>787-620-2530 (Metro Area) Calls to this number are <i>not</i> free.</p> <p>1-866-627-8183 Calls to this number are free.</p> <p>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.</p>
TTY	<p>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.</p> <p>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.</p>
FAX	787-620-7765
WRITE	<p>MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429</p>
MEDICARE WEBSITE	<p>You can submit a complaint about MCS Classicare Patriot (HMO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.</p>

Where to send a request asking us to pay for our share of the cost for medical care 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 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	<p>787-620-2530 (Metro Area) Calls to this number are <i>not</i> free.</p> <p>1-866-627-8183 Calls to this number are free.</p> <p>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.</p>
TTY	<p>1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>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.</p>
FAX	787-620-1337
WRITE	<p>MCS Advantage, Inc. Claims Department PO BOX 191720 San Juan, PR 00919-1720</p>
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	<p>www.Medicare.gov</p> <p>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.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• 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 <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about MCS Classicare Patriot (HMO):</p> <ul style="list-style-type: none">• Tell Medicare about your complaint: You can submit a complaint about MCS Classicare Patriot (HMO) 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. <p>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.)</p>

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.

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

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

SECTION 6 Medicaid

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

To find out more about Medicaid and its programs, contact the Puerto Rico Department of Health - 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.

Method	Puerto Rico Department of Health - Medicaid Program – Contact Information
TTY/TDD	1-787-625-6955 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/

SECTION 7 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 <i>not</i> free.
WEBSITE	rrb.gov/

**SECTION 8 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.

CHAPTER 3:

*Using the plan
for your medical services*

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

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

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

Section 1.1 What are network providers and covered services?

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

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

As a Medicare health plan, MCS Classicare Patriot (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

MCS Classicare Patriot (HMO) 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).
- **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 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 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, you will pay the same as you would pay 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

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

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

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.

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)

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 may assist you in selecting a network specialist and can follow-up after any specialist visit. 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 don't need a referral from your PCP to see a network specialist.

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 must use your *Providers 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 can you get without a referral from your PCP?

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

Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams 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.

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?

As a member of our plan, you may visit any specialist of our network without referral.

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

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 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
 - Specialists' 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.

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

It is important that you know that 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 7.

Section 2.4 How to get care from out-of-network providers
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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 Patriot (HMO) and the out-of-network provider in order to ascertain authorization for services has been obtained.

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

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.

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.

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

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

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

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

MCS Classicare Patriot (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan 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 5 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.

Coverage for Inpatient Hospital Care for this plan is unlimited. 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?
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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 Patriot (HMO), 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 Patriot (HMO) will cover:

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

If you leave MCS Classicare Patriot (HMO) 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 Patriot (HMO). 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 a 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 a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

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

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 in-network 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 in-network covered services count toward this 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 in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of MCS Classicare Patriot (HMO), an important protection for you is that you only have to

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

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 Patriot (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

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

Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

You receive your care from a network provider. In most cases, care you receive from an out-of-network

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

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.

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:

Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 - Chronic alcohol and other drug dependence;
 - Autoimmune disorders;
 - Cancer;
 - Cardiovascular disorders;
 - Chronic heart failure;
 - Dementia;
 - Diabetes;
 - End-stage liver disease;
 - End-stage renal disease (ESRD);
 - Severe hematologic disorders;
 - HIV/AIDS;
 - Chronic lung disorders;
 - Chronic and disabling mental health conditions;
 - Neurologic disorders;
 - Stroke;
 - Crohn's disease;
 - Ulcerative colitis;
 - Chronic anemia;
 - Chronic obstructive pulmonary disease (COPD);
 - Severe mental retardation;

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

- Moderate to Severe Autism;
- Hypertension;
- Valvular heart disease;
- Cerebrovascular disease;
- Chronic viral hepatitis;
- Chronic liver disease;
- Neurodegenerative disease;
- Obesity;
- Chronic Malnutrition or Cachexia;
- Chronic kidney disease;
- Non-pressure chronic ulcer.

New members: You must have one of the aforementioned conditions, you must also have a high risk of hospitalization or other adverse health outcomes, and you must require intensive care coordination. We will validate your condition and confirm your eligibility. Remember, you must remain a member of the plan and meet all the eligibility criteria mentioned above to continue to be eligible for these benefits. **If you are a current member,** your condition and eligibility criteria will be confirmed through the information we have in our system that makes you eligible. Call the plan if you have questions.

- Please go to the *Special Supplemental Benefits for the Chronically Ill* row in the below Medical Benefits Chart for further detail.
- Please contact us to find out exactly which benefits you may be eligible for.




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
<p><i>NOTES:</i></p> <ul style="list-style-type: none"> • <i>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.</i> • <i>† = Cost-sharing does not count for your maximum out-of-pocket. See Section 1.2 in this Chapter.</i> • <i>Legend for column titled: “What You Must Pay”: \$ (copayment), % (coinsurance). See Chapter 12 (Definitions of important words.)</i> 	



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

Services that are covered for you	What you must pay when you get these services
 <p>Abdominal aortic aneurysm screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>
<p>Acupuncture for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • 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. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p>	<p>\$0 copayment for each Medicare-covered service.</p>




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

Services that are covered for you	What you must pay when you get these services
<p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Additional Acupuncture Services</p> <p>Additional Acupuncture services – without the need for diagnosis – are limited to 6 visit(s) every year. These services must be furnished by network providers.</p> <p>Rules and limitations may apply. Please contact the plan for more details.</p>	<p>\$0 copayment[†]</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services</p> <p>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.</p>	<p>\$0 copayment for each Medicare-covered Ground Ambulance service. \$0 copayment for each Medicare-covered Air Ambulance service. <i>Prior Authorization may be required.</i></p>
<p> Annual wellness visit</p> <p>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.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p> Bone mass measurement</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>


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

Services that are covered for you	What you must pay when you get these services
 <p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>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.</p> <p>The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p> <p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p>
 <p>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
 <p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>

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

Services that are covered for you	What you must pay when you get these services
 <p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation <p>Routine chiropractic care</p> <p>Limited to 6 non-Medicare covered routine visit(s) every year (for other non-Medicare covered diagnoses). Please contact the plan for more details.</p>	<p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment[†]</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<p>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. 15% coinsurance applies.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Medicare-covered Barium Enema Preventive Services 	\$0 copayment for each Medicare-covered service.
<p>Dental services</p> <p>Medicare-covered dental services</p> <p>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.</p> <p>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:</p> <p>Diagnostic Services[†]</p> <ul style="list-style-type: none"> • 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 	<p>\$0 for Medicare-covered dental benefits.</p> <p>\$0 copayment per office visit for preventive and diagnostic dental services not covered by Medicare (but covered by the plan).</p> <p>No maximum benefit coverage applies for preventive and diagnostic services.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>benefit does not apply if there are six (6) intraoral periapical radiographic images in a period of one (1) year.</p> <ul style="list-style-type: none"> • 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. <p>Preventive Services †</p> <ul style="list-style-type: none"> • 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. Deciduous molars up to turning 8 years old will be covered when medically necessary because of cavity tendencies. <p>Minor restorative services †</p> <ul style="list-style-type: none"> • 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. <p>Other restorative services †</p>	<p>\$0 copayment for non-routine services, restorative services including crowns, endodontics, periodontics, extractions and oral surgery.</p> <p>\$2,500 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</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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. <p>Major restorative †:</p> <p>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.</p> <p>Crowns †</p> <ul style="list-style-type: none"> • Porcelain/ceramic crown; • Porcelain/metal crown; • Metal crown; • Stainless steel crown; • Indirect and prefabricated resin crown^{3/4} resin crown. <p>* All crowns are limited to one (1) per tooth every five (5) years.</p> <ul style="list-style-type: none"> • 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. <p>Endodontic services †</p> <ul style="list-style-type: none"> • 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 	<p>plan).</p> <p>After the annual maximum is exhausted, any remaining charges are the member's responsibility.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>radiolucency is limited to one (1) per tooth per life.</p> <p>Periodontic services[†]</p> <ul style="list-style-type: none"> • 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. <p>Oral surgery[†]</p>	

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

Services that are covered for you	What you must pay when you get these services
<p>Covered oral surgery services are as follows:</p> <ul style="list-style-type: none"> • 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. <p>Other surgical procedures limited to oral and maxillofacial surgeons[†]</p> <ul style="list-style-type: none"> • 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. <p>Other Services[†]</p> <ul style="list-style-type: none"> • Palliative treatment to treat pain - minor procedure is limited 	

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

Services that are covered for you	What you must pay when you get these services
<p>to one (1) every twelve (12) months.</p> <ul style="list-style-type: none"> • 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. <p>Prosthodontic services †</p> <p>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.</p> <p>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.</p> <p>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</p> <p><u>Removable Prosthodontia</u> †</p> <p>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.</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copayment for prosthodontics: Removable, fixed and implants.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>base).</p> <ul style="list-style-type: none"> • 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. <p><u>Fixed prosthesis</u> †</p> <p>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.</p> <ul style="list-style-type: none"> • 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. <p><u>Implants services</u> †</p> <p>The following services are covered in accordance with the American Dental Association standards of care and with radiographic evidence.</p> <ul style="list-style-type: none"> • 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. 	



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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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. <p>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.</p> <p>Semi precision supporting structure for removable prosthesis over implants are covered once (1) per tooth per life.</p> <p>These services may be offered by a certified provider. These services are covered according to the rules and limitations of the contract.</p> <p>Mini implants or any restoration associated with mini-implants will not be covered. Implants must have the FDA seal and ID of approval.</p> <p>Dental procedures not mentioned in this document are considered not covered.</p> <p>NOTE: If your plan does not have a Point of Service option, dental services will not be covered for out-of-network providers.</p> <p>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:</p>	

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

Services that are covered for you	What you must pay when you get these services
<ol style="list-style-type: none"> 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. <p><i>Some services may require preauthorization, contact the plan for details.</i></p> <p><i>If you have questions, ask your dental health professional or call our plan.</i></p>	
 <p>Depression screening</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> 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. <p>Diabetic Supplies and Services are limited to those from specified manufacturers. Contact the plan for more information.</p>	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p> <p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p> <p>\$0 copayment for each Medicare-covered service.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.)</p> <p>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.</p> <p>With this <i>Evidence of Coverage</i> document, we sent you MCS Classicare Patriot (HMO)'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.</p> <p>Generally, MCS Classicare Patriot (HMO) 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 Patriot (HMO) 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.)</p> <p>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 7, <i>What to do if you have a problem or complaint (coverage decisions, appeals, complaints)</i>.)</p>	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p> <p>Your cost sharing for Medicare oxygen equipment coverage is \$0, every month.</p> <p>Your cost sharing will not change after being enrolled for 36 months in MCS Classicare Patriot (HMO).</p> <p>If prior to enrolling in MCS Classicare Patriot (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in MCS Classicare Patriot (HMO) is \$0.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Worldwide coverage (out of network):</p> <p>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.</p> <p>Please contact the plan for more details.</p>	<p>\$40 copayment for each Medicare-covered service. Copayment is waived if you are admitted to a hospital within 24 hours.</p> <p>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.</p> <p>\$75 copayment[†]</p> <p>Copayment is waived if you are admitted to a hospital.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Foot Reflexology</p> <p>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.</p> <p>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.</p> <p>Additional visits are the enrollee's responsibility, and payable according to regular health care fees.</p> <p>Reimbursement does not apply. Rules and limitations may apply. Contact the plan for information.</p>	<p>\$0 copayment. †</p>
<p> Health and wellness education programs</p> <p>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.</p> <p>Healthy Welcome Program</p> <ul style="list-style-type: none"> • 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 Patriot (HMO) will help you establish an effective relationship with your physician and become more involved in the decisions about your healthcare. 	<p>\$0 copayment †</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Health Education</p> <p>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:</p> <ul style="list-style-type: none"> • 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 [†]
<p>MCS En Alerta</p> <ul style="list-style-type: none"> • 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 [†]

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

Services that are covered for you	What you must pay when you get these services
<p>MCS Medilínea</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>\$0 copayment †</p>
<p>Hearing services</p> <p>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.</p> <p>Additional routine hearing exams Limited to 1 visit(s) every year Please contact the plan for more details.</p> <p>Fitting-evaluation(s) for hearing aids Limited to 1 visit(s) every year Please contact the plan for more details.</p> <p>Hearing aids Please consult "Combined Eyewear and Hearing Allowance" benefit at the end of this chart.</p>	<p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment †</p> <p>\$0 copayment †</p>

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

Services that are covered for you	What you must pay when you get these services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p>


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

Services that are covered for you	What you must pay when you get these services
<p>Home infusion therapy</p> <p>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).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p>
<p>Hospice care</p> <p>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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>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 Patriot (HMO). There is no cost-sharing for hospice consultation.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Hospice care (continued)</p> <p>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> 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).</p> <ul style="list-style-type: none"> • 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) <p><u>For services that are covered by MCS Classicare Patriot (HMO) but are not covered by Medicare Part A or B:</u> MCS Classicare Patriot (HMO) 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.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	

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

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • 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 	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>
<p>Inpatient hospital care</p> <p>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.</p>	<p>Special Network: \$0 copayment for each Medicare-covered hospital stay. \$0 copayment for an unlimited number of additional Medicare-covered days. †</p> <p>General Network: \$50 copayment for each Medicare-covered hospital stay. \$0 copayment for an unlimited number of additional Medicare-covered days. †</p> <p>For Special Network providers and/or facilities, please see the Special Networks section of your Providers Directory.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p>Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules. The hospital cost-sharing is charged on the date of admission, except for emergencies. <i>Prior Authorization may be required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> • 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 Patriot (HMO) 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. <ul style="list-style-type: none"> ○ 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 <u>up to \$10,000[†]</u>, 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 <u>first pint of blood[†]</u> that you need. All components of blood are covered beginning with the first pint used. • Physician services 	<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!</i> 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.</p>	
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>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.</p> <p><i>Some services may require preauthorization through MCS Solutions and certain exceptions may apply.</i></p> <p><i>For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.</i></p>	<p>\$0 copayment for each Medicare-covered hospital stay.</p>



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

Services that are covered for you	What you must pay when you get these services
	<p>Medicare hospital benefit periods apply.</p> <p>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.</p> <p>The hospital cost-sharing is charged on the date of admission, except for emergencies.</p> <p><i>Prior Authorization may be required.</i></p>
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your SNF stays 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:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) 	<p>When your stay is no longer covered, these services will be covered as described in the following sections:</p> <p>Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy <p><i>Some services may require preauthorization, contact the plan for details.</i></p>	<p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer below to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.</p> <p>Please refer to Prosthetic Devices and Related Supplies.</p> <p>Please refer to Prosthetic Devices and Related Supplies.</p> <p>Please refer below to Outpatient Rehabilitation Services.</p>


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

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>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:</p> <ul style="list-style-type: none"> • 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 	<p>0% for Medicare Part B opioid antagonists.</p> <p>10% for all other Medicare Part B drugs (not including Part B chemotherapy/radiation drugs). <i>Prior Authorization is required.</i></p> <p>0% - 10% coinsurance, \$35 maximum copay, for a one-month supply of insulin drugs.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 <p>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.</p> <p>We also cover some vaccines under our Part B prescription drug benefit.</p>	<p>0% for Medicare Part B Radiation Drugs.</p> <p>5% for Medicare Part B Chemotherapy Drugs. <i>Prior Authorization may be required.</i></p> <p>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.</p>
<p>Nutritionist Services</p> <p>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.</p> <p>Any vitamin, supplement or item recommended from such evaluation may not be covered.</p> <p>Please see your Providers Directory for a list of available dietitians.</p> <p>If you want to change your provider after the initial visit, you should contact the plan before making any changes.</p>	<p>\$0 copayment[†]</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Opioid treatment program services</p> <p>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:</p> <ul style="list-style-type: none"> • 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 <p>For details before receiving services, contact the plan.</p>	<p>\$0 copayment for each Medicare-covered service.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations 	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p> <p>0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services).</p> <p>10% coinsurance for each Medicare-covered service. <i>Prior Authorization may be required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the <u>first pint of blood</u>[†] that you need. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests - Non-radiological diagnostic services • Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays 	<p>Your costs may vary depending on your facility/laboratory:</p> <p>Special Network: 0% per service. General Network: 20% per service.</p> <p>For Special Network providers and/or facilities, please see the Special Networks section of your Providers Directory. <i>Prior Authorization may be required.</i></p> <p>\$0 copayment for each Medicare-covered service.</p> <p>0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services). <i>Prior Authorization may be required.</i></p> <p>0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services). <i>Prior Authorization may be required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p>Notes:</p> <p>Some examples of simple diagnostic procedures and tests include, but are not limited to stress tests, electrocardiograms, and electroencephalograms. Some examples of complex services include, but are not limited to: PET and PET CT.</p> <p>Some examples of simple diagnostic and therapeutic radiological services include, but are not limited to radiology exams, sonograms, and radiation therapy (brachytherapy). Some examples of complex services include, but are not limited to MRI and MRA.</p> <p>Contact the plan for details.</p>	
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>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.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> 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.</p>	<p>\$0 copayment for each Medicare-covered service.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> 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.</p>	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>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.</p>	

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Services provided by a psychiatrist • Services provided by other mental health care providers <p><i>Some services may require preauthorization through MCS Solutions and certain exceptions may apply.</i></p> <p><i>For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.</i></p>	<p>\$0 copayment for each Medicare-covered Individual Session.</p> <p>\$0 copayment for each Medicare-covered Group Session.</p> <p>\$0 copayment for each Medicare-covered Individual Session. <i>Prior Authorization is required.</i></p> <p>\$0 copayment for each Medicare-covered Group Session.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p> <ul style="list-style-type: none"> • Services provided by a physical therapist or speech language therapist • Services provided by an occupational therapist 	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p> <p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services</p> <p>Our plan covers treatment for alcoholism and substance dependence in outpatient settings.</p> <p>The outpatient substance dependence treatment services include:</p> <ul style="list-style-type: none"> • 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 <p><i>Call MCS Solutions at 1-800-760-5691, available 24 hours a day, seven (7) days a week.</i></p>	<p>\$0 copayment for each Medicare-covered Individual Session.</p> <p>\$0 copayment for each Medicare-covered Group Session.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>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 <i>outpatient</i>.</p> <ul style="list-style-type: none"> • Services provided at an outpatient hospital • Services provided at an ambulatory surgical center 	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p> <p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization is required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p>Over-the-Counter (OTC) Items</p> <p>You are eligible for a \$230 every month (\$2,760 annually) to be used toward the purchase of over-the-counter (OTC) health and wellness products. If you are eligible to “Special Supplemental Benefits for the Chronically Ill” you will be able to use the allowance for both OTC and additional items with your Te Paga Card.</p> <p>Our plan provides coverage for some OTC drugs and/or items. You do not need a doctor’s prescription to get your OTC drugs and/or items. However, you should talk with your doctor before buying dual-purpose drugs and/or items. These are drugs and/or items used to treat more than one medical condition. We cover a maximum amount of money monthly. 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. To get more information about your available balance and/or where to get OTC drugs and/or items, call the plan. Remember, OTC drugs and/or items can only be obtained for the enrollee.</p> <p>The OTC brands and/or items may vary according to availability at the moment of purchase at the pharmacy you visit. Remember, MCS Advantage, Inc. is not responsible for any manufacturing defect in some products or items. If you find any manufacturing defect, contact the product’s manufacturer directly or the store where you purchased it. Restrictions may apply. Contact the plan for details.</p>	<p>\$0 copayment †</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p> <p>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.</p> <p><i>For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.</i></p>	<p>\$0 copayment per day for each Medicare-covered service.</p>
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Other health care professionals • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment 	<p>\$0 copayment for each Medicare-covered service.</p> <p>See "Outpatient Surgery" earlier in this chart for any applicable cost share amounts for ambulatory surgical center visits or in a hospital outpatient setting.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment for each Medicare-covered service.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 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). <ul style="list-style-type: none"> ○ 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 • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location 	<p>\$0 copayment for each Medicare-covered service. †</p> <p>You will pay the cost-sharing that applies to specialist services (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” above).</p> <p>You will pay the cost-sharing that applies to specialist services (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” above).</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ 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 • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ 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 	<p>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost-sharing that applies to in-person services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p> <p>You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p>You will pay the cost-sharing that applies to specialist services (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” above).</p> <p>You will pay the cost-sharing that applies to specialist services (as described under “Physician/Practitioner Services, Including Doctor’s Office Visits” above).</p> <p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copayment for each Medicare-covered service.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copayment for each Medicare-covered service.</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>



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

Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies</p> <p>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.</p>	<p>10% for each Medicare-covered medical supply.</p> <p>20% for each Medicare-covered prosthetic device. (There is an exception for prosthetic implants, which have 0%.) <i>Prior Authorization may be required.</i></p>
<p>Pulmonary rehabilitation services</p> <p>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.</p>	<p>\$0 copayment for each Medicare-covered service.</p>
<p>Remote Access Technologies (MCS medilíneaMD)</p> <p>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.</p> <p>Children under eighteen (18) years must be accompanied by an adult at the time of consultation.</p> <p>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.</p> <p>In severe cases and those in which the doctor understands merit the 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.</p> <p>If the doctor determines that the patient's condition cannot be treated</p>	<p>\$0 copayment[†]</p>

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

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to four 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>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.</p>	<p>\$0 copayment for each Medicare-covered service.</p> <p>20% coinsurance for each Medicare-covered service.</p> <p>These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>Please refer to Durable Medical Equipment and Related Supplies.</p> <p>Please refer to Home Health Agency Care.</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.)</p> <p>A prior hospital stay is not required. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) 	<p>\$0 copayment for each Medicare-covered skilled nursing facility stay.</p> <p>You are covered for up to 100 days each benefit period for inpatient services in a SNF, in</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 <u>first pint of blood</u>^f 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 <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • 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 	<p>accordance with Medicare guidelines.</p> <p>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. <i>Prior Authorization is required.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> 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.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Special Supplemental Benefits for the Chronically Ill[†]</p> <p>If you have been diagnosed by a qualified provider with certain chronic conditions and you meet certain criteria, you may be eligible for additional benefits.</p> <p>Additional benefits include:</p> <p>Te Paga Card</p> <p>Eligible members may use their OTC 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:</p> <ul style="list-style-type: none"> • OTC Items • Food and produce, and prepared foods • 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. 	<p>\$0 copayment.</p> <p>You have up to \$230 monthly (\$2,760 annually).</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 <p>Electricity, water, phone and Internet bills must be in the member's name in order to access the benefit.</p> <p>Unused allowance amount will be carried over to the next month.</p> <p>At the end of the policy year, the plan will not provide any remaining balance of your benefit.</p> <p>If the transaction exceeds the available balance, you must pay the difference.</p> <p>Cash withdrawal is not allowed.</p> <p>This benefit does not apply for reimbursement.</p> <p>This benefit cannot be used to buy alcoholic beverages nor tobacco or its derivatives.</p> <p>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.</p> <p>Applies only through contracted suppliers.</p> <p>Restrictions may apply. Contact the plan for details.</p>	

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

Services that are covered for you	What you must pay when you get these services
<p>Eligibility requirements:</p> <p>To be eligible for these additional benefits, you must meet the following requirements: You must have one or more comorbid and medically complex chronic conditions that are life-threatening or significantly limit your health or general functioning - see the list of applicable conditions below. In addition, you must have a high risk of hospitalization or other adverse health outcomes; and must require intensive care coordination.</p> <p>Eligible chronic conditions: Chronic alcohol and other drug dependence; Autoimmune disorders; Cancer; Cardiovascular disorders; Chronic heart failure; Dementia; Diabetes; End-stage liver disease; End-stage renal disease (ESRD); Severe hematologic disorders; HIV/AIDS; Chronic lung disorders; Chronic and disabling mental health conditions; Neurologic disorders; Stroke; Crohn's disease; Ulcerative colitis; Chronic anemia; Chronic obstructive pulmonary disease (COPD); Severe mental retardation; Moderate to Severe Autism; Hypertension; Valvular heart disease; Cerebrovascular disease; Chronic viral hepatitis; Chronic liver disease; Neurodegenerative disease; Obesity; Chronic malnutrition and Cachexia; Chronic kidney disease; Non-pressure chronic ulcer.</p> <p>Please contact the plan for details.</p>	<p>health-related needs. Please refer to your transportation 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.</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD).</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>\$0 copayment for each Medicare-covered service. <i>Prior Authorization may be required.</i></p>
<p>Therapeutic massage</p> <p>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.</p> <p>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.</p> <p>Additional visits are the enrollee's responsibility, and payable according to regular health care fees.</p> <p>Reimbursement does not apply. Rules and limitations may apply.</p> <p>Please contact the plan for more details.</p>	<p>\$0 copayment[†]</p>


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

Services that are covered for you	What you must pay when you get these services
<p>Transportation</p> <p>Transportation is one of the benefits included in your health plan.</p> <p>Routine transportation for up to 68 trips every year. 40 of these trips are available to Veterans Administration (VA) facilities exclusively.</p> <p>A trip is considered one-way transportation to a plan approved health-related location through contracted suppliers.</p> <p>Certain limitations and requirements apply.</p> <p>Please contact the plan for more details.</p>	<p>\$0 copayment[†]</p>
<p>Urgently needed services</p> <p>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.</p>	<p>\$0 copayment for each Medicare-covered service.</p>
<p>Worldwide urgent care coverage (out of network):</p> <p>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.</p> <p>Please contact the plan for more details.</p>	<p>\$75 copayment[†]</p> <p>Copayment is waived if you are admitted to a hospital.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • 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.) <p>Routine eye exam Limited to 1 visit(s) every year Please contact the plan for more details.</p> <p>Additional routine eyewear Please consult "Combined Eyewear and Hearing Allowance" benefit at the end of this chart.</p>	<p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment for each Medicare-covered service.</p> <p>\$0 copayment †</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Welcome to Medicare preventive visit</p> <p>The plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the <i>Welcome to Medicare</i> 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 <i>Welcome to Medicare</i> preventive visit.</p> <ul style="list-style-type: none"> • Medicare-covered EKG following Welcome Visit Preventive Services 	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p> <p>\$0 copayment for each Medicare-covered service.</p>
<p>Combined Eyewear and Hearing Allowance</p> <p>MCS will cover the following services under a combined amount of \$1,000 every year for Eyewear and Hearing items:</p> <ul style="list-style-type: none"> • 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. <p>Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.</p> <p>Intraocular lenses are covered under the "Prosthetic Devices and Related Supplies" benefit and apply only to Medicare-covered items.</p>	<p>\$0 copayment[†]</p> <p><i>Prior Authorization may be required.</i> Applies only for Hearing Aids.</p>

SECTION 3 What services are not covered by the plan?**Section 3.1 Services we do not cover (exclusions)**

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

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		<ul style="list-style-type: none"> • 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.
<p>Custodial care</p> <p>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.</p>	Not covered under any condition	
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined Original Medicare to not be generally accepted by the medical community.</p>		<ul style="list-style-type: none"> • May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	

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

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 include basic household assistance, including light housekeeping or light meal preparation.		Home Assistance, a Special Supplemental Benefit for the Chronically Ill, 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		<ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> 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.

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

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		<ul style="list-style-type: none"> 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:

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

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

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

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

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

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

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

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

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

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called balance billing. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain

Chapter 5 Asking us to pay our share of a bill you have received for covered medical services

provider charges.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services 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.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 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.

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.mcsclearicare.com or call 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

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

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care, 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 7 of this document.

CHAPTER 6:

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.)
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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, seeing a women's health specialists or finding a network specialist, 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

Chapter 6 Your rights and responsibilities

accesibilidad incluyen, entre otros, la disposición de servicios de traducción, servicios de interpretación, teletipo 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
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You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

- Your personal health information includes the personal information you gave us when you enrolled

Chapter 6 Your rights and responsibilities

in this plan as well as your medical records and other medical and health information.

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

How do we protect the privacy of your health information?

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

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

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

You have the right to know how your health information has been shared with others for any purposes that 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

Chapter 6 Your rights and responsibilities

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

Chapter 6 Your rights and responsibilities

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

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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.

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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

Chapter 6 Your rights and responsibilities

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.

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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)。

Chapter 6 Your rights and responsibilities**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 Patriot (HMO), 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.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
 - 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.

Chapter 6 Your rights and responsibilities

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5	We must support your right to make decisions about your care
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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.
- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you 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.

Chapter 6 Your rights and responsibilities

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

Chapter 6 Your rights and responsibilities

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.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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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
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There are several places where you can get more information about your rights:

- You can **call our Call Center.**

Chapter 6 Your rights and responsibilities

- 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* document 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.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, 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.
- **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 premium for your Medicare Part B to remain a member of the plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.

Chapter 6 Your rights and responsibilities

- **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 7:

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

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Medicare

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

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

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- See **Section 5.4** of this chapter for more information about Level 2 appeals.

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 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at our Call Center**.
- You **can get free help** from your SHIP.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call 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.mcscare.com.)
 - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **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 another 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.mcscare.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

If you're not sure which section you should be using, please call our Call Center. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

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

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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 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

When a coverage decision involves your medical care, it is called an **organization determination**.

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

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

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care 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.

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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 9 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 information 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 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms

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

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

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

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

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generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

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- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Term

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

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

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Step 1: The independent review organization reviews your appeal.

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

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2

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

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review

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organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called *upholding the decision* or *turning down your appeal*.) In this case, the independent review organization will send you a letter:
 - Explaining its decision
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Telling you how to file a Level 3 appeal.

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

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

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 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 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call 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 about:

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

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- 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 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Call Center. Or call your SHIP, 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

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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 6.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling 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

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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 6.3	Step-by-step: How to make a Level 2 appeal to change your hospital discharge date
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During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at 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

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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. *This is called upholding the decision.*
- 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term

A fast review (or fast appeal) is also called an **expedited appeal**.

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate appeal

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

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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 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The

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reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
 - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 7.1	<i>This section is only about three services:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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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.

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Section 7.2 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 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Call Center. Or call your SHIP, 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 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

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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 7.5.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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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 7.4 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.

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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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 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 start your Level 1 appeal (within a day or two, at the most). 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

Legal Term
A fast review (or fast appeal) is also called an expedited appeal .

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive

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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 9 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

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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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

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

Level 4 appeal The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal**

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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.

MAKING COMPLAINTS

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

Section 9.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?

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Complaint	Example
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Call Center or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • 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 <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>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:</p> <ul style="list-style-type: none"> • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services 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.

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Section 9.2 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 9.3 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.
 - You must file your grievance no later than 60 calendar days of the event that you want us to investigate and 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 an organization determination. You may also file an expedited grievance if we refuse to grant you a request for an expedited organization determination/ expedited coverage determination or reconsideration/redetermination. 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.

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- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 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 9.5 You can also tell Medicare about your complaint

You can submit a complaint about MCS Classicare Patriot (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in MCS Classicare Patriot (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

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

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

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.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.

Chapter 8 Ending your membership in the plan

- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of MCS Classicare Patriot (HMO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply 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 we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.

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.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4	Where can you get more information about when you can end your membership?
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If you have any questions about ending your membership you can:

- **Call our Call Center.**
- Find the information in the *Medicare & You 2024* handbook.

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- 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:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You will automatically be disenrolled from MCS Classicare Patriot (HMO) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from MCS Classicare Patriot (HMO) when your new plan's coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • 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 Patriot (HMO) when your coverage in Original Medicare begins.

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

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your

Chapter 8 Ending your membership in the plan

medical services, items and care through our plan.

- **Continue to use our network providers to receive medical care.**
- **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 Patriot (HMO) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?
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MCS Classicare Patriot (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call 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 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.

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 Patriot (HMO) 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 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, 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 Patriot (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 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.

Chapter 9 Legal notices

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

Chapter 9 Legal notices

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 10:

Definitions of important words

Chapter 10 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.

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services 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 Patriot (HMO), 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 skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

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.

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. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost

Chapter 10 Definitions of important words

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

Covered Services – The term we use to mean all 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.

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

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.

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.

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.

Grievance - A type of complaint you make about our plan or providers, including a complaint concerning

Chapter 10 Definitions of important words

the quality of your care. This does not involve coverage or payment disputes.

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

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

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an *outpatient*.

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 three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

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 in-network covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

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

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 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**

Chapter 10 Definitions of important words

Advantage Plans with Prescription Drug Coverage. MCS Classicare Patriot (HMO) does not offer Medicare prescription drug coverage.

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).

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

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

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan 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 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 received is also referred to as the member's *out-of-pocket* cost requirement.

Chapter 10 Definitions of important words

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

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

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

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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

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

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

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits 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 Patriot (HMO) Call Center

Method	Call Center – Contact Information
CALL	<p>1-866-627-8183 Calls to this number are free. 787-620-2530 (Metro Area) Calls to this number are <i>not</i> 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.</p>
TTY	<p>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.</p>
FAX	787-620-1337
WRITE	<p>MCS Advantage, Inc. Call Center PO BOX 191720 San Juan, PR 00919-1720</p>
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	<p>1-877-725-4300 (San Juan Area)</p> <p>1-800-981-0056 (Mayagüez Area)</p> <p>1-800-981-7735 (Ponce Area)</p>

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

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