January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of MCS Classicare RxMax (HMO)

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

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

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

For questions about this document, call Member Services at 1-866-627-8183 (Toll Free). (TTY users 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 RxMax (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 RxMax (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 Member Services 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, 2028.

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

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of MCS Classicare RxMax (HMO)

Section 1.1 You're enrolled in MCS Classicare RxMax (HMO), which is a Medicare HMO

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

MCS Classicare RxMax (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months you're enrolled in MCS Classicare RxMax (HMO) between January 1, 2027, and December 31, 2027.

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

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.

- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for MCS Classicare RxMax (HMO)

MCS Classicare RxMax (HMO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our 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 move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

Section 2.3 U.S. citizen or national, or an eligible noncitizen

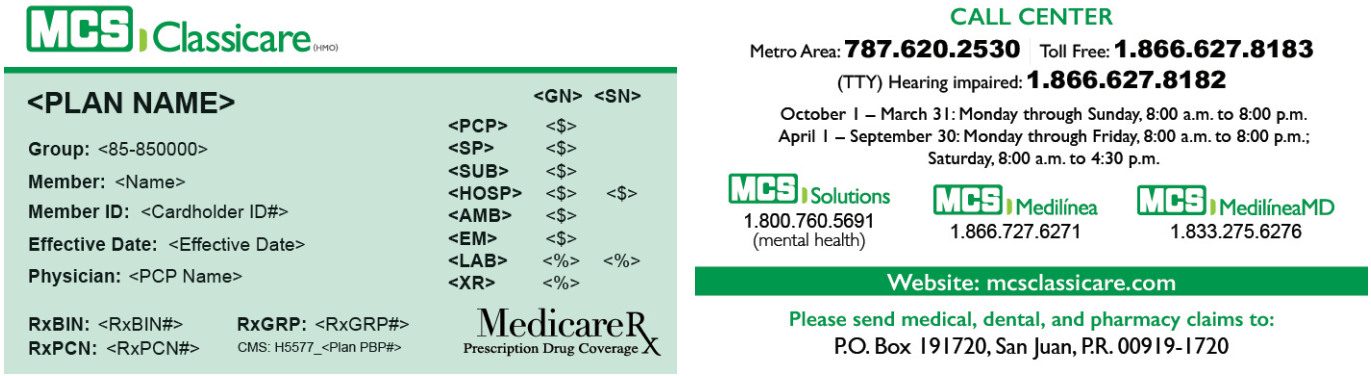
You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify MCS Classicare RxMax (HMO) if you're not eligible to stay a member of our plan on this basis. MCS Classicare RxMax (HMO) must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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs

you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:



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

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) right away and we'll send you a new card.

Section 3.2 Providers and Pharmacies Directory

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when MCS Classicare RxMax (HMO) authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at www.mcsclassicare.com, and in the Mi MCS app. There, you can view the most recent version of the directory, along with a search feature that allows you to easily find your doctors by category, specialty, or municipality, helping you save time and effort. You can also perform advanced searches using other filters, such as the language spoken by the provider, interpreter services, whether the provider accepts new patients, and whether the provider's location is accessible for people with disabilities, among others. Once you perform the search, you will receive a specific list of providers, under the filters you have established, with their information, including office hours, phone number, and physical address. Also, if you access the

directory through your Mi MCS account, you have the option to save your selected providers by pressing the "Add to Favorites" option.

If you don't have a *Providers and Pharmacies Directory* (www.mcsclassicare.com), you can ask for a copy (electronically or in paper form) from Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). Requested paper *Providers and Pharmacies Directory* will be mailed to you within 3 business days.

Section 3.3 Providers and Pharmacies Directory

The *Providers and Pharmacies Directory* (www.mcsclassicare.com) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Providers and Pharmacies Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Providers and Pharmacies Directory*, you can ask for a copy from Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). You can also find this information on our website at www.mcsclassicare.com.

Section 3.4 Drug List (formulary)

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

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.mcsclassicare.com or call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* *Your premium can be higher than this amount. Go to Section 4.1 for details.	$0

	Your Costs in 2027
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	$3,400
Primary care office visits	$0 copayment per visit
Specialist office visits	$0 copayment per visit
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stays starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**Tier 1:** $0 copayment for each Medicare-covered hospital stay. $0 copayment for additional Medicare-covered days. **Tier 2:** $50 copayment for each Medicare-covered hospital stay.
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible:** $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copayment • Drug Tier 2: $5 copayment • Drug Tier 3: $15 copayment You pay $0 per month supply of each covered insulin product on this tier. • Drug Tier 4: $30 copayment

	Your Costs in 2027
	You pay $15 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% coinsurance You pay no more than $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Your costs may include the following:
- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You don’t pay a separate monthly plan premium for MCS Classicare RxMax (HMO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Our plan will have a $20 reduction in your Medicare Part B monthly premium for this contract year.

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

Section 4.3 Part D Late Enrollment Penalty

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

When you first enroll in MCS Classicare RxMax (HMO), we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

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

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

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

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

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

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

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs

(instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

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

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your Part D late enrollment penalty

There are three ways you can pay the penalty.

The three ways you can pay your Part D late enrollment penalty are: payment by check (coupon booklet), Social Security check withdrawal, and automatic deduction. When you enroll for the first time in our plan, you must choose your Part D late enrollment penalty payment option on the Payment Options form. To change the selected payment option, you must fill out the Payment Options form again and mark the Change box.

Remember, the form is available in our service centers. You may also call Member Services and we will mail a form to you.

You can return the completed form to us in person at any of our service centers, via fax to 787-622-2098, or by mail to the following address: MCS Classicare, PO BOX 193310, San Juan, PR 00919-3310.

If you decide to change the way you pay your Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your Part D late enrollment penalty is paid on time.

Option 1: Pay by check

You may pay by check using the coupon booklet: (Checks must be made payable to MCS Classicare, not CMS nor HHS.) You may also pay by money order, credit cards, debit cards, and cash using the coupon booklet. If you request to pay using the coupon booklet at the time of your initial enrollment, you will receive the coupon booklet on or before the new policy year begins, so you can make your payments at our Service Centers, at Banco Popular de Puerto Rico, by phone, by mail, and online.

If for any reason, you lose the coupon booklet, you may call our Member Services to request a new one. The telephone numbers of our Member Services are on the back cover of this document. Your Part D late enrollment penalty payment is due the first (1st) day of each month. You have a grace period of 30 days to send us your payment.

If you make a coupon booklet payment at our service centers, you may pay using a check, money order, credit card, or debit card (ATH). Please be advised that cash payments are not accepted at the Service Centers.

If you make a coupon booklet payment at Banco Popular de Puerto Rico, you may pay using a check, money order, and cash.

If you want to make a coupon booklet payment by phone, you may do so by calling our Member Services: 1-866-627-8183 (Toll Free); 1-866-627-8182 (TTY users); 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. Your phone payment can be made using your VISA credit or debit card, MasterCard credit or debit card, American Express credit or debit card, checking account, or savings account.

If you want to make a coupon booklet payment by mail, you can send a check or money order along with your coupon to: MCS Classicare, PO BOX 70348 San Juan PR 00936-8348.

If you want to make a payment online through Mi MCS on the MCS Classicare website, you may do so using your VISA credit or debit card, MasterCard credit or debit card, American Express credit or debit card, savings account, or checking account. Our payment system is designed to accept monthly payments. However, it also allows you to make payments in advance, provided your account is not in arrears. If you pay with a credit or debit card, your payment will show on your account on the same day of your transaction. If you use a checking or savings account, it can take two (2) to three (3) business days for the payment to show on your account. If the transaction is successful, it will show on your online payment history in two (2) to five (5) business days.

To use this service, you should:

1. Access https://www.mcsclassicare.com.
2. Once you have logged in, you will see an option on the center of the screen titled Mi MCS. Click on the link.
3. You will then see a box to the right side of the screen. If you are a new user, you must sign up. Click on Register.
4. Once you have logged in to the registration page, complete the Registration Form. You will need your plan's identification card. Have it on hand.
5. Complete your payment. If you encounter any problems while making a payment, contact our Member Services.

When your payment is done, the system will give you a confirmation number. Keep a record of these confirmation numbers. You can have a copy of the transaction sent to the email address registered in Mi MCS. You will be able to view your transaction history for the last twelve (12) months through the online payment service.

If you have problems accessing your username or password, visit the Mi MCS login page at http://www.mcsclassicare.com and click on the area that reads Did you forget your password? Click here. You can reset your password from here.

If you have any questions about the online payment option, call us.

If, using any of these methods, the bank rejects any payment method due to insufficient funds, we will continue to make arrangements to collect the amount for the next 20 days after the first attempt. The bank shall be responsible for monitoring the account to collect the funds as soon as they become available.

Option 2: You may make an automatic payment

You may choose to pay using an automatic payment with your bank account (checking account or savings account) or credit card. If you choose this option, the Part D late enrollment penalty amount will be withdrawn from your bank account or charged directly to your credit card on a monthly basis, according to your choosing. This automatic payment will always be effective on the 10th day of the month. If the 10th day falls on a weekend or a holiday, the transaction will be processed the next working day. If the transaction is rejected by the bank due to insufficient funds, we will continue making efforts to collect the amount for the next 20 days after the initial transaction attempt. The bank will be responsible for monitoring the account in order to collect the funds as soon as they become available.

Option 3: Have Part D late enrollment penalties deducted from your monthly Social Security check

Changing the way you pay your Part D late enrollment penalty. If you decide to change how you pay your Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure that your Part D late enrollment penalty is paid on time. To change your payment method, call our Member Services or visit our Service Centers.

If you have trouble paying your Part D late enrollment penalty

Your Part D late enrollment penalty is due in our office by the 1st day of the month. If we don’t get your payment by the 1st day of the month, we’ll send you a notice letting you know your plan membership will end if we don’t get your Part D late enrollment penalty, if owed, within 90 calendar days. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your Part D late enrollment penalty, if owed, on time, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn’t pay your Part D late enrollment penalty, if owed, you’ll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without

creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for unpaid penalties. We have the right to pursue collection of the amount you owe. If you want to enroll again in our plan (or another plan that we offer) in the future, you will need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-866-627-8183 (Toll Free) between Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.. (TTY users call 1-866-627-8182). You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty.

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

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Member Services 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

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

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

  - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 MCS Classicare RxMax (HMO) contacts

For help with claims, billing, or member card questions, call or write to MCS Classicare RxMax (HMO) Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Member Services 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) also has free language interpreter services for non-English speakers.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties 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. Member Services PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. For more information on how to ask for coverage decisions about your medical care, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	787-620-1336
Write	MCS Advantage, Inc. Clinical Affairs Department PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

How to make an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision. For more information on making an appeal about your medical care, go to Chapter 9.

Appeals for Medical Care – Contact Information	
Call	1-866-627-8183 Calls to this number are free.

Appeals for Medical Care – Contact Information	
	Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	787-620-7765
Write	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
Website	www.mcsclassicare.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.

Complaints about Medical Care – Contact Information	
	Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	787-620-7765
Write	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
Medicare website	To submit a complaint about MCS Classicare RxMax (HMO) directly to Medicare, go to Medicare.gov/my/medicare-complaint

How to ask for a coverage decision about your Part D drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your Part D drugs. For more information on how to ask for coverage decisions about your Part D drugs, go to Chapter 9.

Coverage Decisions for Part D Drugs – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	1-866-763-9097
Write	MCS Advantage, Inc. Pharmacy Department

Coverage Decisions for Part D Drugs – Contact Information	
	PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

How to ask for an appeal about your Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for an appeal about your Part D drugs, go to Chapter 9.

Appeals for Part D Drugs – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	1-866-763-9097
Write	MCS Advantage, Inc. Pharmacy Department PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

How to make a complaint about your Part D drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn’t involve coverage or payment disputes. For more information on making a complaint about your Part D drugs, go to Chapter 9.

Complaints about Part D drugs – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	787-620-7765
Write	MCS Advantage, Inc. Grievances and Appeals Unit P.O. Box 195429 San Juan, PR 00919-5429
Medicare Website	You can submit a complaint about MCS Classicare RxMax (HMO) directly to Medicare. To submit an online complaint to Medicare go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

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

Payment Requests – Contact Information	
Call	1-866-627-8183 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.

Payment Requests – Contact Information	
	Calls to this number are free.
TTY	1-866-627-8182 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30.
Fax	787-620-1337
Write	MCS Advantage, Inc. Claims Department PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

Medicare – Contact Information	
	Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about MCS Classicare RxMax (HMO). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Puerto Rico, the SHIP is called State Health Insurance Assistance Program.

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

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

	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 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://www.oppea.pr.gov/programas-y-servicios

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.

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

	Commence Health (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, Sunday, and Holidays from 10:00 a.m. to 4:00 p.m. 24-hour voicemail, case status updates, and online appeal services are available.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454
Website	https://www.commencehealthqio.cms.gov/en

SECTION 5 Social Security

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

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

Social Security— Contact Information	
Call	1-800-772-1213 Calls to this number are free.

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

SECTION 6 Medicaid

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

To find out more about Medicaid and Medicare Savings Programs, contact the Puerto Rico Department of Health - Medicaid Program.

	Puerto Rico Department of Health - Medicaid Program – Contact Information
Call	787-641-4224 Monday through Friday from 8:00 a.m. to 5:00 p.m.
TTY/TDD	1-787-625-6955 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Medicaid Program Puerto Rico Department of Health PO BOX 70184 San Juan, PR 00936-8184

	Puerto Rico Department of Health - Medicaid Program – Contact Information
	prmedicaid2@salud.pr.gov
Website	https://www.medicaid.pr.gov/CMS/4

SECTION 7 Programs to help people pay for prescription drugs

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

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

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

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

Note: To be eligible for the ADAP in your State, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 787-765-2929, exts. 5103, 5136, or 5137.

Medicare Prescription Payment Plan

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

this payment option, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or visit Medicare.gov.

The Medicare Prescription Payment Plan – Contact Information	
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Member Services 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.
Write	MCS Advantage, Inc. Pharmacy Department PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free.

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3:

Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

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

MCS Classicare RxMax (HMO) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you will have to pay the provider in full for services you get. Here are 3 exceptions:
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Before seeking care, contact the plan to know if the service requires coordination or prior authorization. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get medical care

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

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

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 getting 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 Member Services 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 to choose a PCP?

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

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. 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 Member Services at the telephone number mentioned in the back cover of this booklet. When you call, make sure to tell our Member Services representative if you are seeing specialists or getting other covered services that need your PCP's approval. Our Member Services 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 Medical care you can get without a PCP referral

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

- Routine women's health care, including 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 vaccines, Hepatitis B vaccines, and pneumonia vaccines as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're 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. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions

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

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 prior authorization (PA) from the plan

There are certain services that require prior authorization from your plan. The benefits that require prior authorization are mentioned in Chapter 4, Section 2 of this booklet.

How to request a prior authorization

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

- Written medical order including:
  - Name of the member
  - Member’s contract number
  - Order emission date
  - ICD10 diagnosis code and/or description
  - Service or procedure code requested
  - 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.

- The clinical guidelines used for evaluations of prior authorization requests are available through our website www.mcsclassicare.com

When a specialist or another network provider leaves our plan

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

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

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

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

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

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

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You may receive covered emergency or urgent medical care when you are temporarily outside the United States and its territories through the Worldwide Coverage benefit. For more information about plan rules, please refer to Emergency Care and Urgently Needed Services in the Benefits Chart in Chapter 4.

- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You may call our Member Services (phone numbers are printed on the back cover of this booklet).

Covered services in a medical emergency

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

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

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

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

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

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

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. Worldwide 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.

Section 3.3 Get care during a disaster

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

Visit www.mcsclassicare.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

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

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

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

MCS Classicare RxMax (HMO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. 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 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

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

Coverage for Inpatient Hospital Care for this plan is unlimited. Please go to the Medical Benefits Chart (what's covered and what you pay) in Chapter 4 for additional information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of MCS Classicare RxMax (HMO), you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what’s covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of MCS Classicare RxMax (HMO). This section also gives information about medical services that aren’t covered and explains limits on certain services.

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

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

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

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

Section 1.2 What’s the most you’ll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services 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 2027 the MOOP 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. The amounts you pay for Part D drugs don’t count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don’t count toward your maximum out-of-pocket amount. These services are marked with the following sign (†) in the

Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $3,400, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates in Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

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

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

- **Autoimmune disorders** (Polyarteritis Nodosa; Polymyalgia Rheumatica; Polymyositis; Rheumatoid Arthritis; Rheumatologic Disease; Spondylopathies; Systemic Lupus Erythematosus; Wegener's Granulomatosis)
- **Cancer** (Excluding precancerous conditions or in situ status)
- **Cardiovascular disorders** (Cardiac Arrhythmias; Chronic Venous Thromboembolic Disorder; Coronary Artery Disease; Myocardial Infarction; Peripheral Vascular Disease; Valvular Heart Disease)
- **Cerebrovascular disease**
- **Chronic alcohol use disorder and other substance use disorders, SUDs** (chronic alcohol use disorder; nicotine dependence; substance use disorders)
- **Chronic and disabling mental health conditions** (Bipolar disorders; Bipolar disorders and schizophrenia; Major depressive disorders; Moderate to Severe autism; Personality and behavioral disorders; Schizoaffective disorder; Schizophrenia; Severe mental retardation)
- **Chronic anemia**
- **Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell** (Albinism; Blindness and low vision; Hearing loss)
- **Chronic gastrointestinal disease** (Chronic gastritis; Chronic liver disease; Chronic viral hepatitis; Cirrhosis; Crohn's Disease; Diseases of stomach and duodenum; Disorders of gallbladder, biliary tract and pancreas; Disorders of intestine; Gastro-Esophageal Reflux Disease; Gastrointestinal ulcers; Hepatic failure; Hepatic fibrosis; Ulcerative Colitis)
- **Chronic heart failure**
- **Chronic kidney disease (CKD)**
- **Chronic lung disorders** (Asthma; Chronic bronchitis; Chronic obstructive pulmonary disease; Emphysema; Pneumoconiosis; Pulmonary fibrosis; Pulmonary hypertension)
- **Conditions associated with cognitive impairment** (Developmental disorders; Intellectual disabilities; Neurocognitive disorders; Neurological disorders)
- **Conditions that require continued therapy services in order for individuals to maintain or retain functioning** (Motor disorders)
- **Conditions with functional challenges** (Congenital/Genetic disorders; Disorders of muscle; Neuromuscular disorders; Psychological/Behavioral disorders)
- **Dementia** (Alzheimer's disease; Dementia)
- **Diabetes mellitus**
- **HIV/AIDS**
- **Chronic Hypertension** (Hypertension)
- **Immunodeficiency and Immunosuppressive disorders** (Disorders involving the immune mechanism; Immunodeficiency disorders; Sarcoidosis)
- **Neurologic disorders** (Amyotrophic lateral sclerosis ALS; Epilepsy; Extensive Paralysis; Huntington disease; Multiple Sclerosis; Myoneural disorders; neurodegenerative diseases; Parkinson's disease; Polyneuropathy; Spinal stenosis; Stroke-related neurologic deficit)
- **Non-pressure chronic ulcer**
- **Overweight, obesity, and metabolic syndrome** (Cachexia; Obesity)

- **Post-organ transplantation** (status/complication)
- **Severe hematologic disorders** (Aplastic anemia; Hemophilia; Immune thrombocytopenic purpura; Myelodysplatic syndrome; Sickle-cell disease)
- **Stroke**
- **Chronic Malnutrition**

Who is eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI)?

Special Supplemental Benefits for the Chronically Ill (SSBCI) are available only to eligible members who are determined by the plan to be chronically ill and for whom the benefit has a reasonable expectation of improving or maintaining health or overall function.

To qualify for SSBCI you must:

- Meet the CMS definition of a chronically ill member, as determined by the plan using objective criteria; and
- Be determined by the plan to have a reasonable expectation that the benefit will improve or maintain your health or overall function.

Having one of the conditions listed above does not, by itself, qualify you for SSBCI. You must meet all applicable eligibility criteria described below.

For the purpose of determining eligibility for Special Supplemental Benefits for the Chronically Ill (SSBCI), a chronically ill member is someone who:

- Has one or more serious, ongoing health conditions that are life-threatening or significantly affect their overall health or ability to perform daily activities, and
- Has health conditions that place them at high risk of hospitalization or other serious health problems, and,
- Require intensive care coordination.

How do we determine eligibility for special supplemental benefits for the chronically ill?

We determine your eligibility through approved plan processes using objective information. This determination may be based on information obtained through health risk assessments, care management assessments, provider documentation or recommendations, claims information, and other plan approved objective sources. Your self-attestation alone is not sufficient to establish eligibility. To remain eligible for these benefits, you must continue to be enrolled in the plan and meet all applicable eligibility criteria.

- For more details, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly for which benefits you may be eligible.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
NOTES: • *Cost share is based on the service received and the setting where it is performed. Additional cost share may apply when other services are performed.* • † = *Cost-sharing does not count for your maximum out-of-pocket. See Section 1.2 in this Chapter.* • *Legend for column titled:* ***"What You Pay"****: $ (copayment), % (coinsurance). See Chapter 12 (Definitions of important words.)*	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:**	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Acupuncture for chronic low back pain - continued	
Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
Additional Acupuncture Services	
Additional Acupuncture services – without the need for diagnosis – are limited to 6 visit(s) every year. These services must be furnished by network providers. Rules and limitations may apply. Please contact our plan for more details.	$0 copayment †
Ambulance services	
Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that	$0 copayment for each Medicare-covered Ground Ambulance service. $0 copayment for each Medicare-covered Air Ambulance service. *Prior Authorization may be required.*

Covered Service	What you pay
Ambulance services - continued other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Covered Service	What you pay
Cardiac rehabilitation services	
Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	
We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

Covered Service	What you pay
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation	$0 copayment for each Medicare-covered service.
Routine chiropractic care Limited to 6 non-Medicare covered routine visit(s) every year (for other non-Medicare covered diagnoses). Please contact our plan for more details.	$0 copayment †
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren’t at high risk	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

Covered Service	What you pay
Colorectal cancer screening - continued	
for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. 10% coinsurance applies.

Covered Service	What you pay
Dental services	
Medicare Part A will pay for certain dental services that a beneficiary receives when they're in a hospital. Medicare can pay for hospital stays if a beneficiary needs to have an emergency or complicated dental procedure. In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:	$0 for Medicare-covered dental benefits.
Oral Exams†	
• 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. • One (1) 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 (1) every six (6) months. For endodontists, an evaluation applies when medically necessary.	$0 copayment per office visit for Oral Exams, Dental X-Rays, Other Diagnostic Dental Services, Prophylaxis (Cleanings), Fluoride Treatment, and Other Preventive Dental Services not covered by Medicare (as long as covered by the plan).
Dental X-Rays†	
• 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	

Covered Service	What you pay
benefit does not apply if there are six (6) intraoral periapical radiographic images in a period of one (1) year. • Six (6) intraoral periapical radiographic images per policy year. This benefit will be limited if a complete series of intraoral periapical radiographic images or one (1) extraoral panoramic radiographic image has been benefited. • One (1) set of radiographic bitewing images per policy year. • Cone beam CT for both jaws, when medically necessary, with or without cranium one (1) per policy year. **Other Diagnostic Dental Services**† • One (1) 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. For endodontists, up to four (4) pulp vitality tests per visit. **Prophylaxis (Cleanings)**† • One (1) oral prophylaxis every six (6) months. **Fluoride Treatment**† • Topical application of fluoride, excluding varnish, every six (6) months. This service applies for patients up to them turning 19 years of age.	
Other Preventive Dental Services† • Fissure sealant per tooth. This service is limited to one (1) per tooth per life in unrestored posterior permanents for patients up to 14 years of age, only on occlusal surfaces. These teeth cannot have been previously restored. Decidual molars up to 8 years of age will be covered when medically necessary because of cavity tendencies. If a restoration is made on the same tooth in less than six (6) months, the sealant will be considered part of the	No maximum benefit coverage applies for preventive and diagnostic services.

Covered Service	What you pay
restorative benefit for that tooth. For dentists, this will be considered part of the same fee as the restored tooth. • Fixed and removable unilateral and bilateral space maintainers (maxillary or mandibular); limited to one (1) per arch or per area for life, for replacement of deciduous molars. • Re-cementing or re-bond of space maintainer; limited to one (1) per maintainer for life.	
Restorative Services† **Minor Restorative Services**† • Amalgam or resin-based composite restorations in primary and permanent teeth will be covered every twenty-four (24) months per tooth. If the dentist needs to redo a previous restoration and add a surface, only the added surface will be covered. The surfaces previously covered will be patient's responsibility. • Placement of interim direct restoration 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.	$0 copayment for Restorative Services, Endodontics, Periodontics, Removable Prosthodontics, Implant Services, Fixed Prosthodontics, Oral and Maxillofacial Surgery, and Adjunctive General Services. $2,500 every year – plan coverage limit for Restorative Services, Endodontics, Periodontics, Removable Prosthodontics, Implant Services, Fixed Prosthodontics, Oral and Maxillofacial Surgery, and Adjunctive General Services not covered by Medicare (but covered by this plan).
Major Restorative Services: **Crowns**† Benefits for individual crowns are limited. If the treatment fails and/or a new treatment plan option that involves the already	After the annual maximum is exhausted, any remaining

Covered Service	What you pay
benefited tooth is required, all coverage for new treatment of the benefited tooth will be the patient's sole responsibility. If a crowned tooth needs to be replaced, no benefits from fixed prostheses, removable prostheses, or implants, will be granted to the patient until five (5) years after cementation. Tooth must be periodontally healthy, restorable, and free of endodontic lesions. Splinted crowns, and crowns built for cosmetic purposes or to correct congenital anomalies are not covered. *All crowns on natural teeth are limited to one (1) per tooth every five (5) years. Re-cementation or reattachment of crowns are limited to one (1) per tooth per life, six (6) months after initial cementation. **Crowns – Individual Restorations Only**† • Porcelain/ceramic crown; • Porcelain/metal crown; • Metal crown; • Stainless steel crown. **Crowns - Single Implants**† • Single crowns, abutment-supported or implant-supported (all-metal or porcelain-fused to metal, noble or high noble, or porcelain) are covered one (1) per tooth per life. *Implant-related crowns are limited to one (1) per tooth per life. A maximum of three (3) implant-supported crowns will be covered per member per policy year. Re-cementation or reattachment of crowns are limited to one (1) per tooth per life, six (6) months after initial cementation. If an implant-supported crown needs to be replaced, no benefits from fixed prostheses or implants will be granted to the patient	charges are the member's responsibility. Before requesting or receiving dental services, please contact Member Services to validate the remaining balance available for your covered dental services.

Covered Service	What you pay
until five (5) years after cementation. If the treatment fails and/or a new treatment plan option that involves the already benefited implant-supported crown is required, all coverage for new treatment will be the patient's sole responsibility.	
Endodontic Services †	
• Endodontic therapy (root canal) in all permanent teeth is limited to one (1) per tooth per life for each service.	
• Pulpotomy is limited to one (1) per tooth per life.	
• Pulp debridement is limited to one (1) per tooth per life.	
• Direct or indirect pulp capping is limited to one (1) per tooth per life.	
• Endodontic retreatment for previously endodontically treated teeth, which are symptomatic or present periapical radiolucency is limited to one (1) per tooth per life. Limited to endodontists.	
• Apicoectomy (in anterior, premolar, and molar teeth) and retrograde filling, one (1) per root per tooth; limited to one (1) in a lifetime. Limited to endodontists and maxillofacial surgeons.	
• Apexification/recalcification, three (3) visits; limited to one per tooth for life. Limited to endodontists and maxillofacial surgeons.	
• Root amputation; limited to one (1) molar root for life. Limited to endodontists, periodontists, and maxillofacial surgeons.	
• Hemisection, for molar teeth, one (1) for life. Limited to endodontists, periodontists, and maxillofacial surgeons.	
Periodontic Services †	

Covered Service	What you pay
• 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 one (1) per life. • Gingival flap procedure is limited to one (1) every three (3) years per quadrant. Limited to periodontist. Limited if you have already benefited from bone surgery. • Clinical crown lengthening – 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, retained natural tooth, first site in 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, retained natural tooth, each additional site in 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 periodontal treatment and limited if you have already benefited from oral prophylaxis. Limited to periodontist.	

Covered Service	What you pay
• Apically positioned flap, limited to one (1) per quadrant for life.	
Prosthodontic Services†	
A single category among the following options applies: removable or fixed prostheses over natural teeth, implant-supported removable or fixed prostheses, including all their components, according to your dentist's recommendations and to the rules and limitations of your coverage. Limited to one (1) prosthesis per arch (maxillary and/or mandibular) every five (5) years and limited by any other fixed or removable prosthesis benefited in dental history.	
All prosthodontic services require an adaptation period. Prosthodontic benefits include adjustments as needed for the first six (6) months. The patient is responsible for contacting the dental provider for evaluation if discomfort is experienced.	
If the prosthesis treatment fails, and/or a change to the initial treatment or a different treatment alternative involving the already benefited tooth or arch is requested, coverage for both new treatment and changes to initial treatment will be the patient's sole responsibility.	
Retainers and pontics for fixed-bridge implants or abutment-supported implants will be covered one (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 only for existing teeth in the edentulous space will be covered one (1) per tooth per life.	
If a fixed bridge component requires replacement with an implant, crown, or removable bridge, the patient will not be granted the benefit again until five (5) years after cementation.	
Prosthodontics, Removable†	
The following prosthetic services are covered in accordance with the American Dental Association standards of care and with	

Covered Service	What you pay
radiographic evidence. Limited to one (1) removable prosthesis per arch (maxillary and/or mandibular) every five (5) years and limited by any other fixed or removable prostheses benefited in dental history. Restorations of implant-supported removable prostheses are limited to a maximum of three (3) implants with semi-precision attachments, per member per policy year. Removable prostheses (maxillary and mandibular) limit each other, and other prosthetic restorations (fixed prostheses over natural teeth, implant-supported fixed prostheses, implant-supported removable prostheses, including all their components) will also limit the benefit. • Complete removable dentures. • Complete immediate removable dentures. • Removable partial dentures, acrylic or metal base. • Removable unilateral partial denture (resin, metal and flexible base). • Flexible removable partial dentures. Adjustments, replacements, and repairs are not covered for flexible partial dentures. • Removable complete and partial dentures, implant-supported. Repairs and adjustments of full mandibular or maxillary dentures, maxillary or mandibular partial 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.	
Prosthodontics, Fixed† The following prosthetic services are covered in accordance with the American Dental Association standards of care and with radiographic evidence. Limited to one (1) prosthesis per arch (maxillary and/or mandibular) every five (5) years and limited by any other fixed or removable prosthesis benefited in dental	

Covered Service	What you pay
history. Fixed bridge limited to one (1) per tooth per life, as detailed. Implant-related fixed prosthesis restorations are limited to a maximum of three (3) retainers per member per policy year. • 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, abutment-supported or implant-supported. • Porcelain/ceramic retainer crown, abutment-supported or implant-supported. • Metal retainer crown, abutment-supported or implant-supported. • 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. A natural tooth with a crown history cannot be used as a retainer for a fixed bridge until five (5) years after the crown has been cemented.	
Implant Services† The following services are covered in accordance with the American Dental Association standards of care and with radiographic evidence. Implant surgery is limited to one (1) per tooth per life. A maximum of three (3) implants (three (3) teeth) will be covered per member per policy year. Only implants in specific teeth that have not benefited from fixed prostheses, removable prostheses or crowns in the previous five (5) years will be covered.	

Covered Service	What you pay
• Endosteal implant surgery to replace teeth is covered one (1) per tooth per life. • Prefabricated or custom fabricated abutments are covered one (1) per tooth per life. Semi-precision support structures for removable prostheses on implants are covered one (1) per tooth per life, up to a maximum of three (3) support structures per member per policy year. If the implant fails and/or a new treatment option is required involving the already benefited implant, full coverage of the new treatment and implant removal will be the patient's responsibility. These services may be offered by a certified provider. Implants must have the FDA seal and ID of approval. These services are covered according to the rules and limitations of the contract. Mini implants or any restoration associated with mini implants will not be covered. **Oral and Maxillofacial Surgery†** Covered oral surgery services are as follows: • Removal of coronal remnants, erupted teeth, exposed roots, and surgical extractions are 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.	

Covered Service	What you pay
• Removal of exostosis (maxilla or mandible), removal of torus palatinus or torus mandibularis is limited to one (1) per arch every five (5) years. • Frenectomy is limited to one (1) per arch for life. • Closure of oroantral fistula limited by exposure.	
Other Oral and Maxillofacial Surgery, limited to oral and maxillofacial surgeons†	
• Primary closure of maxillary sinus perforation. Limited by exposure. • Tooth reimplantation or stabilization of displaced or avulsed tooth caused by accident. Limited to one (1) per tooth for life. • Surgical access of an unerupted tooth; limited to one (1) per tooth for life. • Incisional biopsy of oral tissue (soft and hard); limited to one (1) per lesion. • Surgical repositioning of tooth, limited to one (1) per tooth for life. • Alveoloplasty in conjunction with extractions; limited to one (1) per arch for life. • Alveoloplasty not in conjunction with extractions; limited to one (1) per quadrant for life. • Vestibuloplasty, limited to one (1) per arch for life. • Removal of a completely bone impacted tooth with unusual surgical complication, one (1) per tooth for life. • Excision of hyperplastic tissue, per arch; limited to one (1) for life.	

Covered Service	What you pay
• Excision of pericoronal gingiva; limited to one (1) per tooth for life.	
Adjunctive General Services †	
• Palliative treatment to treat pain - minor procedure, is limited to one (1) every twelve (12) months. • Deep or moderate sedation is covered for extractions and removal of impacted teeth, when performed in a dental office. The first fifteen (15) minutes are covered, and a single additional increment of fifteen (15) minutes, for a maximum of thirty (30) minutes. Covered only for extractions, and for other services covered with medical justification. Limited to oral and maxillofacial surgeon and pediatric dentist. • Visits to hospitals or ambulatory surgical centers for dental treatments. Not covered for oral and maxillofacial surgeon. • Occlusal adjustment, limited or complete. Covered only for patients active in periodontal treatment.	
General Rules: Dental procedures not mentioned in this document are considered not covered. Only justified and covered treatment will be covered by the plan. NOTE: If your plan does not have a Point of Service option, dental services will not be covered for out-of-network providers. The following services are considered general exclusions and must be applied in all cases, unless MCS states otherwise, in writing, and due to the individual coverage design of a particular group: 1. Services provided for cosmetic purposes.	

Covered Service	What you pay
2. Services provided to correct a vertical dimension or occlusion. 3. Splinted crowns for teeth with periodontal problems are not covered. Splinted crowns are also not covered in any clinical or cosmetic scenario. 4. Crowns built for cosmetic purposes or to correct congenital anomalies are not covered. 5. Total maxillary or mandibular reconstructions. 6. 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. 7. Services related to Temporomandibular Joint Syndrome (TMJ). 8. Replacements of minor restorations (resins and amalgams), as well as major restorations (crowns, removable and/or fixed prostheses and implants) 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. 14. The fees for protective equipment and trays are not charges covered or paid by the medical plan, nor do they apply for reimbursement. 15. Bridges with posterior cantilever pontics are not covered.	

Covered Service	What you pay
Some services may require Prior Authorization, contact the plan for details. *If you have questions, ask your dental health professional or call our plan.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. Our plan covers blood glucose monitors and test strips that are included on the plan's preferred product list and obtained through	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies - continued	
participating providers. Coverage for non-preferred brands or manufacturers may be available when determined to be medically appropriate by your prescribing provider. If you are currently using a covered blood glucose monitor or test strips that are no longer preferred under the plan, coverage may continue for a limited transition period. During this time, you should work with your prescribing provider to determine the most appropriate product for your medical needs. If you disagree with your prescribing provider's recommendation, you may request a second opinion.	
• For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) includes fitting	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
• Diabetes self-management training under certain conditions	$0 copayment for each Medicare-covered service.
Diabetic Supplies and Services are limited to those from specified manufacturers. Contact the plan for more information.	
Durable medical equipment (DME) and related supplies	
(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps,	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*

Covered Service	What you pay
Durable medical equipment (DME) and related supplies - continued speech generating devices, oxygen equipment, nebulizers, and walkers.	
With this *Evidence of Coverage* document, we sent you MCS Classicare RxMax (HMO)'s list of DME. The list shows the brands and manufacturers of DME we cover. The most recent list of brands, manufacturers, and suppliers is also available on our website at www.mcsclassicare.com. Generally, MCS Classicare RxMax (HMO) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to MCS Classicare RxMax (HMO) and are using a brand of DME not on our list, we'll 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 after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your provider) don't agree with our plan's coverage decision, you or your provider can 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, go to Chapter 9.)	Your cost sharing for Medicare oxygen equipment coverage is $0, every month. Your cost sharing won't change after being enrolled for 36 months in MCS Classicare RxMax (HMO). If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in MCS Classicare RxMax (HMO), your cost sharing in MCS Classicare RxMax (HMO) is $0.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman,	$40 copayment for each Medicare-covered service. Copayment is waived if you are admitted to a hospital within 24 hours. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order for

Covered Service	What you pay
Emergency care - continued	
loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	your care to continue to be covered.
Worldwide coverage (Out-of-Network) Worldwide coverage includes emergency care and urgent services outside the United States and its territories. Coverage is managed through reimbursement based on different fee schedules allowed by our plan, which are applied according to the service received, less the corresponding cost sharing amount. Please contact our plan for more details.	$75 copayment † Copayment is waived if you are admitted to a hospital.
Foot reflexology Medically necessary, non-pharmacologic pain management alternatives are available to you. You may find relief from foot reflexology. This therapy stimulates the nerves so pain signals are interrupted from travelling to other parts of the body. Foot reflexology services are limited to 6 visits per year. These services must be ordered by a physician or a medical professional; and must be furnished by network providers. Additional visits are the enrollee's responsibility, and payable according to regular health care fees. **Reimbursement does not apply. Rules and limitations may apply. Contact the plan for information.**	$0 copayment. †
Health and wellness education programs As part of MCS Advantage, Inc.'s commitment to the health and well-being of our members, we have developed various	

Covered Service	What you pay
Health and wellness education programs - continued	
educational initiatives and designed innovative wellness programs that take into consideration the membership's needs to achieve optimum health. These wellness programs offer a variety of experiences that benefit your social, emotional, intellectual, and physical health to meet expectations of what a complete health plan should offer.	
Healthy Welcome Program • After your enrollment, you will receive a call to help you coordinate your first complete health evaluation appointment with your physician. • This service allows us to offer you the continuous and preventive care you need, according to your medical history. • MCS Classicare RxMax (HMO) will help you establish an effective relationship with your physician and become more involved in the decisions about your healthcare.	$0 copayment †
Health Education Through our Health Education initiatives, you will benefit from a variety of experiences to support your health and well-being. We offer you activities (both online and face-to-face) that promote social, emotional, intellectual, and physical health. These include: • Health lectures: Include topics for managing health conditions such as diabetes, cardiovascular diseases, and respiratory conditions, among others. Also, the promotion of a healthy lifestyle, stress management, nutrition, physical activity, preventive care, and mental health, among others. • Preventive reminders: To promote healthy actions that lead to well-being and to prevent certain health conditions through early detection and/or management. Topics include preventive care tests, treatment adherence, use	$0 copayment †

Covered Service	What you pay
Health and wellness education programs - continued and abuse of alcohol and drugs, emotional and mental health, among others. • Support interventions: Different workshops to support your wellness and improve your quality of life from a holistic approach. The topics include financial education, gardening, the arts, motivation, among others. • Technology workshops: As part of our wellness program, we offer technology workshops aimed at promoting the use of technology to benefit your health and as part of your healthcare. Topics include the use of electronic devices, how to navigate the internet safely, app downloads, telemedicine and others. • Exercise Program: This benefit allows you to participate in exercise sessions offered by certified fitness instructors and other health professionals, in 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 on the island.	
MCS Medilínea • This is a 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. • To contact MCS Medilínea, please call 1-866-727-6271.	$0 copayment [†]
MCS En Alerta	$0 copayment [†]

Covered Service	What you pay
Health and wellness education programs - continued • Through MCS En Alerta, we promote prevention by providing valuable information, helpful tips and educational content to help you stay prepared and protect yourself from potential natural events such as hurricanes, earthquakes, floods, and fires, among others. For more information about any of our health and wellness programs, call Member Services.	
Hearing services	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 copayment for each Medicare-covered service.
Additional routine hearing exams Limited to 1 visit(s) every year Please contact our plan for more details.	$0 copayment †
Fitting-evaluation(s) for hearing aids Limited to 1 visit(s) every year Please contact our plan for more details.	$0 copayment †
Hearing aids Up to $800 per ear every year for hearing aids. This includes repair of devices. If the hearing aid(s) you purchase costs more than what our plan covers, you pay the difference.	
All types Limited to 2 hearing aid(s) every year	$0 copayment † *Prior Authorization may be required.*

Covered Service	What you pay
Hearing services - continued Please contact our plan for more details.	
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*

Covered Service	What you pay
Home infusion therapy - continued	
(for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	
Hospice care	
You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for	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 RxMax (HMO). There is no cost-sharing for hospice consultation.

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

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services	**Special Network:** $0 copayment for each Medicare-covered hospital stay. $0 copayment for an unlimited number of additional Medicare-covered days. † **General Network:** $50 copayment for each Medicare-covered hospital stay. $0 copayment for an unlimited number of additional Medicare-covered days. † For Special Network providers and/or facilities, please see the Special Networks section of

Covered Service	What you pay
Inpatient hospital care - continued	
• Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside 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 RxMax (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. ○ Transplant travel benefit - If you're sent by our Plan outside of your community (outside Puerto Rico) for a Medicare-covered transplant, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion up to $10,000†, through reimbursement. Certain restrictions may apply, contact our plan for details. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† you need. All components of blood are covered beginning with the first pint used. • Physician services	your Providers and Pharmacies Directory. 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. *Prior Authorization may be required.* 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.

Covered Service	What you pay
Inpatient hospital care - continued **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. • Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available on the Web at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.	
Inpatient services in a psychiatric hospital	
Covered services include mental health care services that require a hospital stay.	$0 copayment for each Medicare-covered hospital stay.
You get up to 190 days of inpatient psychiatric hospital care during your lifetime. Inpatient psychiatric hospital services count towards the 190-day lifetime limit only if certain conditions are met. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. *Some services may require prior authorization through MCS Solutions and certain exceptions may apply.* *For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	Medicare hospital benefit periods apply. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The hospital cost-sharing is charged on the date of

Covered Service	What you pay
Inpatient services in a psychiatric hospital - continued	
	admission, except for emergencies. *Prior Authorization may be required.*
Inpatient stay: Covered services you get in a SNF during a non-covered stay	
If you've used up your SNF benefits, we won't cover your stay. In some cases, we'll cover certain services you get while you're in the skilled nursing facility (SNF). Covered services include, but aren't limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
• Physician services	Please refer to Physician/Practitioner Services, Including Doctor's Office Visits.
• Diagnostic tests (like lab tests)	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.

Covered Service	What you pay
Inpatient stay: Covered services you get in a SNF during a non-covered stay - continued	
• X-ray, radium, and isotope therapy including technician materials and services	Please refer to Outpatient Diagnostic Tests and Therapeutic Services and Supplies.
• Surgical dressings	Please refer to Durable medical equipment (DME) and related supplies
• Splints, casts, and other devices used to reduce fractures and dislocations	Please refer to Durable medical equipment (DME) and related supplies
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer to Prosthetic and Orthotic Devices and Related Supplies.

Covered Service	What you pay
Inpatient stay: Covered services you get in a SNF during a non-covered stay - continued	
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer to Prosthetic and Orthotic Devices and Related Supplies.
• Physical therapy, speech therapy, and occupational therapy *Some services may require prior authorization, contact the plan for details.*	Please refer below to Outpatient Rehabilitation Services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP)	
MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle. You are eligible if you're at risk of developing type 2 diabetes, and all of these conditions apply to you: 1. Within 12 months before attending your first core session, you have either a: • Hemoglobin A1c test result between 5.7% and 6.4% • Fasting plasma glucose of 110-125mg/dL • 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) 2. You have a body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian). 3. You've never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD). Contact the plan for more information.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs	
These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services* • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)	**Other Medicare Part B Drugs** 0% coinsurance for Medicare Part B opioid antagonists. You also pay 0% coinsurance for Part B drugs whose cost paid by the plan is $950 or less for a monthly supply of the drug. *Prior Authorization may be required.*

Covered Service	What you pay
Medicare Part B drugs - continued	
• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment.* • Clotting factors you give yourself by injection if you have hemophilia* • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug*	20% coinsurance for specialty Medicare Part B drugs whose cost paid by the plan is higher than $950 for a monthly supply of the drug. *Prior Authorization may be required.* **Medicare Part B Insulin Drugs** $35 copayment for a one-month supply of insulin drugs.
• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision* • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does* • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic	**Medicare Part B Chemotherapy/Radiation Drugs** 0% coinsurance for Medicare Part B generic Chemotherapy Drugs and Radiation Drugs. *Prior Authorization may be required.* 20% coinsurance for Medicare Part B brand Chemotherapy Drugs. *Prior Authorization may be required.*

Covered Service	What you pay
Medicare Part B drugs - continued	
regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs coverered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases* • Parenteral and enteral nutrition (intravenous and tube feeding)	The plan offers step therapy for Part D to Part B, Part B to Part B, and Part B to Part D.
The following categories of Medicare Part B drugs could also be subject to Step Therapy requirements: • Antimetabolites • Autoimmune disease drugs • Complement Inhibitors • Rheumatoid Arthritis drugs • Ulcerative Colitis drugs • Ophthalmic Agents	

Covered Service	What you pay
Medicare Part B drugs - continued *Categories of Medicare Part B drugs that could be subject to Step Therapy requirements. This link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://mcsclassicare.com/Documents/EN/partb-st-2026-en.pdf We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Nutritionist Services Limited to 10 visit(s) for individual or group sessions every year. Group visits will be organized according to the schedule published by MCS Classicare. Contact us for details. All our enrollees may receive a personal evaluation and diet plan designed by a licensed dietitian according to their health needs, including exercise suggestions. Any vitamin, supplement or item recommended from such evaluation may not be covered. Please see your Providers and Pharmacies Directory for a list of available dietitians. If you want to change your provider after the initial visit, you should contact our plan before making any changes.	$0 copayment †
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated	There is no coinsurance, copayment, or deductible for

Covered Service	What you pay
Obesity screening and therapy to promote sustained weight loss - continued	
with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	preventive obesity screening and therapy.
Opioid treatment program services	
Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments For details before receiving services, contact our plan.	$0 copayment for each Medicare-covered service.
Outpatient diagnostic tests and therapeutic services and supplies	
Covered services include, but aren't limited to:	
• X-rays	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
• Radiation (radium and isotope) therapy including technician materials and supplies	0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services). *Prior Authorization may be required.*
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	10% coinsurance for each Medicare-covered service. *Prior Authorization may be required.*
• Laboratory tests	Your costs may vary depending on your facility/laboratory: Special Network: 0% per service. General Network: 20% per service. For Special Network providers and/or facilities, please see the Special Networks section of your Providers and Pharmacies Directory. *Prior Authorization may be required.*
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† you need. All components of blood are covered beginning with the first pint used.	$0 copayment for each Medicare-covered service.
• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.	0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services). *Prior Authorization may be required.*

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies - continued	
• Other outpatient diagnostic tests - Radiological diagnostic services, not including x-rays	0% - 20% coinsurance depending on the Medicare-covered service. (0% for simple services; 20% for complex services). *Prior Authorization may be required.*
Notes: 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. 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. Contact the plan for details.	
Outpatient hospital observation	
Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Outpatient hospital observation - continued **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note**: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*

Covered Service	What you pay
Outpatient mental health care	
Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	
• Services provided by a psychiatrist	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization may be required.* $0 copayment for each Medicare-covered Group Session.
• Services provided by other mental health care providers	$0 copayment for each Medicare-covered Individual Session. *Prior Authorization may be required.* $0 copayment for each Medicare-covered Group Session.
Some services may require prior authorization through MCS Solutions and certain exceptions may apply. *For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	

Covered Service	What you pay
Outpatient rehabilitation services	
Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
• Services provided by a physical therapist or speech language therapist	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
• Services provided by an occupational therapist	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Outpatient substance use disorder services	
Our plan covers treatment for alcoholism and other substance dependence in outpatient settings. The outpatient substance dependence treatment services include: • Screening and counseling for people who show signs and symptoms 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, clinical social worker, or psychologist's office in outpatient services	$0 copayment for each Medicare-covered Individual Session. $0 copayment for each Medicare-covered Group Session.

Covered Service	What you pay
Outpatient substance use disorder services - continued • Group and individual therapy *Call MCS Solutions at 1-800-760-5691, available 24 hours a day, seven (7) days a week.*	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
• Services provided at an outpatient hospital	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
• Services provided at an ambulatory surgical center	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Over-the-Counter (OTC) Items You are eligible for $64 every month ($768 annually) to be used toward the purchase of some over-the-counter (OTC) health and wellness products through the OTC debit card. If you are eligible for "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.	$0 copayment †

Covered Service	What you pay
Over-the-Counter (OTC) Items - continued **Plan rules:** • 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. • Unused allowance amount **will be carried over** to the next month within the plan year. 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. • 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. For information on Special Supplemental Benefits for the Chronically Ill, see Section 2 in this chapter, under "Important Benefit Information for Enrollees with Chronic Conditions."	
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family	$0 copayment per day for each Medicare-covered service.

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services - continued	
therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$0 copayment per day for each Medicare-covered service.
For more information about MCS Solutions, call 1-800-760-5691, available 24 hours a day, seven (7) days a week.	
Physician/Practitioner services, including doctor's office visits	
Covered services include:	
• Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	$0 copayment for Medicare-covered primary care office visits. For cost-sharing related to surgeries, refer to our Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers.
• Consultation, diagnosis, and treatment by a specialist	$0 copayment for each Medicare-covered service.
• Other health care professionals	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment	$0 copayment for each Medicare-covered service.
• Certain telehealth services, including: Primary Care Physician Services, Physician Specialist Services, Individual Sessions for Mental Health Specialty Services, and Individual Sessions for Psychiatric Services. In the Providers and Pharmacies Directory, you may check to see if your doctor offers telehealth services. Mental health providers (psychologists, social workers, counselors, among others) offering this service are listed under the cybertherapy category in the directory, while primary care physicians and other specialists are listed under the telemedicine category. To find these physicians using the directory search tool on our website (www.mcsclassicare.com), click the "other filters" button and select cybertherapy and/or telemedicine, depending on the type of service you are looking for. ○ 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 your provider directly for details.	$0 copayment for each Medicare-covered service. †
• 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	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued	
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to in-person services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).
• Second opinion by another network provider prior to surgery	You will pay the cost-sharing that applies to specialist services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" above).

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits - continued • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$0 copayment for each Medicare-covered service.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Covered Service	What you pay
Prostate cancer screening exams	
For men aged 50 and older, covered services include the following once every 12 months:	
• Digital rectal exam	$0 copayment for each Medicare-covered service.
• Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic and orthotic devices and related supplies	
Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. Only Medicare-covered intraocular lenses are covered.	10% coinsurance for each Medicare-covered medical supply. *Prior Authorization may be required.* 20% coinsurance for each Medicare-covered prosthetic device. (There is an exception for prosthetic implants, which have 0%.) *Prior Authorization may be required.*
Pulmonary rehabilitation services	
Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$0 copayment for each Medicare-covered service.

Covered Service	What you pay
Remote Access Technologies (MCS medilíneaMD)	
MCS medilíneaMD provides Remote Access Technology services, better known as Telemedicine, that allow you to receive urgent medical care from anywhere within Puerto Rico, 24 hours a day, 365 days a year. You have access to health consultations for a minor illness with a general practitioner or licensed emergency physician. Telemedicine visits can be done by smartphone, computer or tablet. Children under eighteen (18) years must be accompanied by an adult at the time of consultation. Consulting conditions for this service include but are not limited to: allergies, runny nose, nasal congestion, sneezing, constipation, cough, diarrhea, ear problems, moderate fever, flu, headache, insect bites, nausea, conjunctivitis, skin rash, sore throat and vomiting. In severe cases, and those 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. If the doctor determines that the patient's condition cannot be treated through this Telemedicine platform, the patient shall be referred to an emergency room, an urgency center or his/her primary doctor. The patient is responsible for checking their Evidence of Coverage and Prescription Drug Formulary to determine whether MCS Classicare shall cover certain prescriptions. This service does not replace your doctor. This service does not include consultations with medical specialists or sub-specialists, except for those mentioned previously. It does not apply for services outside the contracted Telemedicine platform. Reimbursement does not apply. Refill prescriptions or prescriptions for supplies higher than thirty (30) days shall not be issued, except in cases where medical criteria deem it necessary. In some cases, a seven (7)-day prescription will be issued to meet the patient's needs while the	$0 copayment †

Covered Service	What you pay
Remote Access Technologies (MCS medilíneaMD) - continued patient contacts their primary care physician. Prescriptions for maintenance medications shall not be issued. Prescriptions for controlled substances as described by the Drug Enforcement Administration (DEA), non-therapeutic medications, or other drugs that may be harmful due to their potential for abuse will not be issued. You will be able to have a virtual visit via MCS medilíneaMD through the Mi MCS app, or visit our website at www.mcsclassicare.com. You can also contact the MCS medilíneaMD health professionals by calling 1.833.275.6276 (toll-free) or 1.844.981.1499 (TTY).	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

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

Covered Service	What you pay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	
We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease	
Kidney disease and dialysis services include:	
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime	$0 copayment for each Medicare-covered service.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	20% coinsurance for each Medicare-covered service.
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient Hospital Care.

Covered Service	What you pay
Services to treat kidney disease - continued	
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for each Medicare-covered service.
• Home dialysis equipment and supplies	Please refer to Durable Medical Equipment and Related Supplies.
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	Please refer to Home Health Agency Care.
Skilled nursing facility (SNF) care	
(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) A prior hospital stay is not required.	$0 copayment for each Medicare-covered skilled nursing facility stay.
Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.
• Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood† you need. All components of blood are covered beginning with the first pint used.	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.

Covered Service	What you pay
Skilled nursing facility (SNF) care - continued • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	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. *Prior Authorization may be required.*
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
Special supplemental benefits for the chronically ill †	
If you have been diagnosed by a qualified provider with certain chronic conditions, and you meet certain eligibility criteria, you may receive additional benefits. For a description of the clinical criteria and eligibility requirements, please refer to Section 2, titled "*Important Benefit Information for Enrollees with Chronic Conditions*," in Chapter 4.	
Special supplemental benefits include:	
• OTC Items • Food and produce, and prepared foods • Pest control items (sprays, traps) • Pet food and supplies to support eligible enrollees' social isolation needs. • 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. This also includes hurricane preparedness items: First aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. You may also pay for utilities, such as electricity, water, telephone, cable, and Internet bills. • Social needs: Includes access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - club memberships, park passes, and musical events. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts. Passes to events/activities are only covered for the enrollee, not their companion, and are non-transferable. • Services supporting self-direction: Fundamental, continuing education classes supporting technology use, English language, and financial literacy. • Physical fitness: Items, sports equipment, and services related to promoting muscle tone and balance for reduced	$0 copayment. You have up to $64 monthly ($768 annually). **The allowance mentioned above is combined with the Over-the-Counter (OTC) Items allowance.**

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued risk of falls and injuries and overall health and well-being. Equipment covered may include kettlebells, weights, yoga mats, resistance bands. • Memory and cognitive function support: 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. • Alternative therapies: They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common alternative health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi. A variety of natural products, including herbs, dietary supplements, and prebiotic or probiotic products. Electricity, water, phone and Internet bills must be in the member's name in order to access the benefit. Unused allowance amount **will be carried over** to the next month within the plan year. At the end of the policy year, the plan will not provide any remaining balance of your benefit. You may obtain the benefits described above via the SSBCI debit card (Te Paga Card). If the transaction exceeds the available balance, you must pay the difference. If your Te Paga card cannot be used at the point of sale, and you obtain a covered benefit from an out-of-network provider, you may purchase the covered item or service and request reimbursement from the plan for eligible expenses. To request reimbursement, you must submit a completed reimbursement claim, along with any required supporting documentation, such as an itemized receipt and proof of payment, within the time frame specified by the plan. The plan will review the claim and reimburse	

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued	
eligible covered expenses in accordance with applicable coverage rules and plan requirements. You must submit your Part C (supplemental benefits) claim before the end of the contract year in which the benefit was used or the transaction occurred. Mail your request for payment together with any bills or paid receipts to us at this address: Payment Request for Supplemental Benefits MCS Advantage, Inc. – Operations Department PO BOX 191720 San Juan, PR 00919-1720 The benefit cannot be used for cash withdrawal nor purchase the following services or products: cosmetic procedures, hospital indemnity insurance, funeral planning and expenses, life insurance, alcohol, tobacco, cannabis products that are illegal under State or Federal law, broad membership programs inclusive of multiple unrelated services and discounts, and non-healthy food. MCS is not responsible for any product or item defects. If any defect is found, you must contact the service provider directly or the product manufacturer. Applies only through contracted suppliers. Restrictions may apply. Contact the plan for details.	
Transportation for non-medical needs • In addition to enjoying the transportation benefit to attend medical appointments, pharmacies and laboratories, you have the ability of using this benefit for non-medical matters. For example, going to the grocery store or the bank, among others.	$0 for each one-way trip or return trip each year. Each one-way trip or return trip means one individual trip. **The Transportation for Non-Medical Needs is**

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued	
• Applies only to plan approved locations through contracted suppliers. • Remember to call for transportation 3 to 5 business days before your appointment. Contact the plan for more details and for the phone numbers of the transportation provider assigned to your municipality. • Restrictions may apply. Contact the plan for details.	**combined with the base package transportation for 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.
Home Assistance Services • Home Assistance services include: plumbing, locksmith, electricity, preventive home cleaning/disinfection, pest control, technology assistance, yard clean-up, and hairstyling (barber/salon services for wash, cut and dry). • For hairstyling/barber/salon services, you must visit participating establishments to receive these services. • Services are limited to sixteen (16) visits per year. A maximum of four (4) visits applies per quarter. If the full number of visits is not used in a quarter, the balance of visits is not carried over to be used in the next quarter. Quarterly periods are from January to March; from April to June; from July to September; and from October to December. • Only simple repairs and basic services apply for this benefit, according to the evaluation performed by the service supplier. • Repairs will be made only if damages are related to the member's home and if they occurred inside of the home itself. • MCS Classicare is not responsible of any defect in manufacture of any certain products or items. If any defect	$0 for home assistance services.

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued is found, you must contact the service supplier or the product manufacturer directly. • Applies only through contracted suppliers. • Reimbursement does not apply. • Restrictions may apply. Contact the plan for details. **Eligibility requirements related to chronic conditions:** Special Supplemental Benefits for the Chronically Ill (SSBCI) are available only to eligible members who are determined by the plan to be chronically ill and for whom the benefit has a reasonable expectation of improving or maintaining health or overall function. **To qualify for SSBCI you must:** • Meet the CMS definition of a chronically ill member, as determined by the plan using objective criteria; and • Be determined by the plan to have a reasonable expectation that the benefit will improve or maintain your health or overall function. Having one of the conditions listed below does not, by itself, qualify you for SSBCI. You must meet all applicable eligibility criteria described below. For the purpose of determining eligibility for Special Supplemental Benefits for the Chronically Ill (SSBCI), a chronically ill member is someone who: • Has one or more serious, ongoing health conditions that are life-threatening or significantly affect their overall health or ability to perform daily activities, and • Has health conditions that place them at high risk of hospitalization or other serious health problems, and,	

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued • Require intensive care coordination. **How do we determine eligibility for special supplemental benefits for the chronically ill?** We determine your eligibility through approved plan processes using objective information. This determination may be based on information obtained through health risk assessments, care management assessments, provider documentation or recommendations, claims information, and other plan approved objective sources. Your self-attestation alone is not sufficient to establish eligibility. To remain eligible for these benefits, you must continue to be enrolled in the plan and meet all applicable eligibility criteria. Contact us to find out exactly for which benefits you may be eligible. **Eligible chronic conditions:** **Autoimmune disorders** (Polyarteritis Nodosa; Polymyalgia Rheumatica; Polymyositis; Rheumatoid Arthritis; Rheumatologic Disease; Spondylopathies; Systemic Lupus Erythematosus; Wegener's Granulomatosis); **Cancer** (Excluding precancerous conditions or in situ status); **Cardiovascular disorders** (Cardiac Arrhythmias; Chronic Venous Thromboembolic Disorder; Coronary Artery Disease; Myocardial Infarction; Peripheral Vascular Disease; Valvular Heart Disease); **Cerebrovascular disease**; **Chronic alcohol use disorder and other substance use disorders, SUDs** (chronic alcohol use disorder; nicotine dependence; substance use disorders); **Chronic and disabling mental health conditions** (Bipolar disorders; Bipolar disorders and schizophrenia; Major depressive disorders; Moderate to Severe autism; Personality and behavioral disorders; Schizoaffective disorder; Schizophrenia; Severe mental retardation); **Chronic anemia**; **Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell** (Albinism; Blindness and low vision; Hearing loss); **Chronic gastrointestinal disease** (Chronic gastritis; Chronic liver disease; Chronic viral hepatitis; Cirrhosis; Crohn's Disease; Diseases of	

Covered Service	What you pay
Special supplemental benefits for the chronically ill† - continued	
stomach and duodenum; Disorders of gallbladder, biliary tract and pancreas; Disorders of intestine; Gastro-Esophageal Reflux Disease; Gastrointestinal ulcers; Hepatic failure; Hepatic fibrosis; Ulcerative Colitis); **Chronic heart failure**; **Chronic kidney disease, CKD**; **Chronic lung disorders** (Asthma; Chronic bronchitis; Chronic obstructive pulmonary disease; Emphysema; Pneumoconiosis; Pulmonary fibrosis; Pulmonary hypertension); **Conditions associated with cognitive impairment** (Developmental disorders; Intellectual disabilities; Neurocognitive disorders; Neurological disorders); **Conditions that require continued therapy services in order for individuals to maintain or retain functioning** (Motor disorders); **Conditions with functional challenges** (Congenital/Genetic disorders; Disorders of muscle; Neuromuscular disorders; Psychological/Behavioral disorders); **Dementia** (Alzheimer's disease; Dementia); **Diabetes mellitus**; **HIV/AIDS**; **Chronic Hypertension** (Hypertension); **Immunodeficiency and Immunosuppressive disorders** (Disorders involving the immune mechanism; Immunodeficiency disorders; Sarcoidosis); **Neurologic disorders** (Amyotrophic lateral sclerosis, ALS; Epilepsy; Extensive Paralysis; Huntington disease; Multiple Sclerosis; Myoneural disorders; neurodegenerative diseases; Parkinson's disease; Polyneuropathy; Spinal stenosis; Stroke-related neurologic deficit); **Non-pressure chronic ulcer**; **Overweight, obesity, and metabolic syndrome** (Cachexia; Obesity); **Post-organ transplantation** (status/complication); **Severe hematologic disorders** (Aplastic anemia; Hemophilia; Immune thrombocytopenic purpura; Myelodysplatic syndrome; Sickle-cell disease); **Stroke**; and **Chronic Malnutrition.** **Please contact the plan for details.**	

Covered Service	What you pay
Supervised exercise therapy (SET)	
SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$0 copayment for each Medicare-covered service. *Prior Authorization may be required.*
Therapeutic Massage	
Medically necessary, nonpharmacologic pain management alternatives are available to you. You may find relief from therapeutic massage, which helps break the "pain" cycle whilst reducing associated muscle tightness, among other benefits. Therapeutic massage services are limited to 6 visits per year. These services must be ordered by a physician or a medical professional and must be furnished by network providers. Additional visits are the enrollee's responsibility, and payable according to regular health care fees. Reimbursement does not apply. Rules and limitations may apply.	$0 copayment [†]

Covered Service	What you pay
Therapeutic massage - continued Please contact our plan for more details.	
Transportation Transportation is one of the benefits included in your health plan. Routine transportation for up to 22 trips every year. A trip is considered one-way transportation to a plan approved health-related location through contracted suppliers. A round trip is considered as two (2) individual trips. Remember to call for transportation 3 to 5 business days before your appointment. Contact the plan for more details and for the phone numbers of the transportation provider assigned to your municipality. Certain limitations and requirements apply. Please contact our plan for more details.	$0 copayment †
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.	$0 copayment for each Medicare-covered service.
Worldwide coverage (Out-of-Network)	$75 copayment †

Covered Service	What you pay
Urgently needed services - continued	
Worldwide coverage includes emergency care and urgent services outside the United States and its territories. Coverage is managed through reimbursement based on different fee schedules allowed by our plan, which are applied according to the service received, less the corresponding cost sharing amount. Please contact our plan for more details.	Copayment is waived if you are admitted to a hospital.
Vision care	
Covered services include:	
• Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts	$0 copayment for each Medicare-covered service.
• For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older	$0 copayment for each Medicare-covered service.
• For people with diabetes, screening for diabetic retinopathy is covered once per year	$0 copayment for each Medicare-covered service.
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery	$0 copayment for each Medicare-covered service.
Routine eye exam Limited to 1 visit(s) every year Please contact our plan for more details.	$0 copayment †

Covered Service	What you pay
Vision care - continued	
Additional routine eyewear Up to $500 every year for all additional routine eyewear. If the eyewear you purchase costs more than our plan covers, you pay the difference.	
• **Contact lenses**	$0 copayment †
• **Eyeglass frames**	$0 copayment †
• **Eyeglass lenses**	$0 copayment †
• **Eyeglasses (lenses and frames)**	$0 copayment †
Please contact the plan for more details. Benefit and maximum plan coverage amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. Intraocular lenses are covered under the "Prosthetic and Orthotic Devices and Related Supplies" benefit and apply only to Medicare-covered items.	

Covered Service	What you pay
Welcome to Medicare preventive visit	
Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.
• Medicare-covered EKG following Welcome Visit Preventive Services	$0 copayment for each Medicare-covered service.

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

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household help, including light housekeeping or light meal preparation	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	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) is covered after each cataract surgery that implants an intraocular lens.
Reversal of sterilization procedures and / or non-prescription contraceptive supplies	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Out-of-network services	Please refer to exceptions described in Chapter 3, Sections 1.2 and 2.4

CHAPTER 5:

Using plan coverage for Part D drugs

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

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2 or you can fill your prescription through our plan's mail-order service.)
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

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

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Providers and Pharmacies Directory*, visit our website (www.mcsclassicare.com), and/or call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or use the *Providers and Pharmacies Directory*. You can also find information on our website at www.mcsclassicare.com.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Providers and Pharmacies Directory* www.mcsclassicare.com or call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

Section 2.2 Our plan's mail-order service

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

Our plan's mail-order service requires you to order **a *90*-day supply for covered drugs, excluding Specialty drugs, and a 30-day supply for Specialty drugs.**

To get order forms and information about filling your prescriptions by mail, call Member Services or go to our website to download the form (www.mcsclassicare.com). You must use a mail order pharmacy from our pharmacy network; otherwise your prescription drugs will not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail-order may be delayed. If you need an immediate supply, please call Member Services at the numbers mentioned on the back cover of this document; or you may request a 30-day supply from your physician. Please explain to your pharmacist what happened and have them call Member Services for an authorization.

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

Refills on mail-order prescriptions. For maintenance drug refills, contact your pharmacy 15 days before your current prescription will run out. For specialized drugs (tier 5) contact your pharmacy 5 days before your current prescription will run out. This is to make sure your next order is shipped to you on time.

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

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Providers and Pharmacies Directory* www.mcsclassicare.com tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. **Check first with Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182)** to see if there's a network pharmacy nearby.

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

- In special circumstances, including illness, emergency, urgency or loss of prescription drugs while traveling outside of our plan's service area where there is no network pharmacy.
- For self-administred drugs purchased out-of-network: members may ask for reimbursement or ask the plan for an exception through the plan's exception process. Please, contact the plan for details.
- Please note: The Part D drugs will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation or who does not have a valid record of opting-out of Medicare. Out-of-Network drugs are covered as long as your medication is prescribed by a medical professional with an active and unrestricted license to practice within the United States and commonwealth countries, and according to other plan rules.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

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

- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Five (5) cost-sharing tiers for drugs on the Drug List

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

- Tier 1: Includes preferred generic drugs. This is the lowest cost-sharing tier.
- Tier 2: Includes generic drugs.
- Tier 3: Includes preferred brand drugs.
- Tier 4: Includes non-preferred drugs.
- Tier 5: Includes specialty drugs. This is the highest cost-sharing tier.

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

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.mcsclassicare.com). The Drug List on the website is always the most current.
- Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (https://www.medimpact.com/plan/mcs) to search for drugs on the Drug List to get an estimate of what you'll pay and if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-866-627-8183 (Toll Free). (TTY users call 1-866-627-8182). Members must register using an email address and create a username and password.

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the

most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or on our website www.mcsclassicare.com.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.** Our plan's step therapy criteria can be obtained by calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or on our website www.mcsclassicare.com.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

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

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

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

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

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

You may be able to get a temporary supply

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

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

- **For those who have a level of care change:** If you have a level of care change (for example, you were discharged from the hospital to your home), we will cover a temporary 31-day supply (unless you have a prescription written for fewer days). If you need a drug that is not on our formulary or, if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For questions about a temporary supply, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-866-627-8183 (Toll Free), (TTY users call 1-866-627-8182), to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

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

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

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

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

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

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

In general, changes that won't affect you during the current plan year are:

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

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

SECTION 7 Types of drugs we don't cover

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

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

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

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

DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may have cost sharing.)

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

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. This plan covers excluded drugs as part of our Part D supplemental coverage; specifically, we cover some erectile dysfunction drugs: seven (7) sildenafil pills (generic for Viagra) per month or seven (7) vardenafil pills (generic for Levitra) per month. Generic drugs (tier 2) cost sharing applies. The amount you pay for these drugs doesn't count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for the drugs that aren't normally covered. Go to our plan's Drug List or call Member Services 1-866-627-8183 (Toll Free), (TTY users, call1-866-627-8182) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Providers and Pharmacies Directory* www.mcsclassicare.com to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

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

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

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

Special note about creditable coverage:

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

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

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

Section 9.4 If you're in a Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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

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

- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

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

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

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

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over the counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-866-627-8183 (TTY users call 1-866-627-8182).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you**.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (https://www.medimpact.com/plan/mcs), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

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

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

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

Section 1.2 How Medicare calculates your out-of-pocket costs

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

These payments are included in your out-of-pocket costs

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

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

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Prescription drugs and vaccines covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for MCS Classicare RxMax (HMO) members

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

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

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

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

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

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

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

- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled**. This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). Be sure to keep these reports.

SECTION 4 There is no deductible for MCS Classicare RxMax (HMO)

There is no deductible for MCS Classicare RxMax (HMO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

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

Our plan has five (5) cost-sharing tiers

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

- Tier 1 - Includes preferred generic drugs. This is the lowest cost-sharing tier.
- Tier 2 - Includes generic drugs.
- Tier 3 - Includes preferred brand drugs.
- Tier 4 - Includes non-preferred drugs.
- Tier 5 - Includes specialty drugs. This is the highest cost-sharing tier.
- Tier 3: You pay $0 per month supply of each covered insulin product on this tier.
- Tier 4: You pay $15 per month supply of each covered insulin product on this tier.
- Tier 5: You pay no more than $35 per month supply of each covered insulin product on this tier.

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Providers and Pharmacies Directory* at www.mcsclassicare.com.

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

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

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

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	*** Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost- Sharing Tier 1 (Preferred Generic Drugs)	$0	Mail order is not available for drugs in Tier 1.	$0	$0
Cost- Sharing Tier 2 (Generic Drugs)	$5	Mail order is not available for drugs in Tier 2.	$5	$5
Cost- Sharing Tier 3 (Preferred Brand Drugs)	$15	Mail order is not available for drugs in Tier 3.	$15	$15
Cost- Sharing Tier 4 (Non-Preferred Drugs)	$30	Mail order is not available for drugs in Tier 4.	$30	$30

Tier	Standard retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	* Out-of-network cost sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost- Sharing Tier 5 (Specialty Drugs)	33%	33%	33%	33%

* ***Out-of-network:*** *You pay the in-network cost-share plus the difference between the in-network cost and the out-of-network cost for covered prescription drugs received from a non-network pharmacy.*

You won't pay more than $0 for Tier 3, $15 for Tier 4, and $35 for Tier 5 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

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

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

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

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

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

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

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

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

Tier	Standard retail cost sharing (in-network) (up to a 60-day supply)	Standard retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (90-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	$0	$0	$0
Cost-Sharing Tier 2 (Generic Drugs)	$10	$15	$10
Cost-Sharing Tier 3 (Preferred Brand Drugs)	$30	$45	$30
Cost-Sharing Tier 4 (Non-Preferred Drugs)	$60	$90	$60
Cost-Sharing Tier 5 (Specialty Drugs)	A long-term supply is not available for drugs in Tier 5.		Mail order is not available for drugs in Tier 5.

NeDS: *Not all drugs in tiers 1 through 4 are available for extended supply. These drugs are marked as "NeDS" in our Drug Formulary.*

FFQL: *In order to provide you and your doctor with an opportunity to properly assess the effectiveness of a drug, only the first prescription fill will be covered for 30 days for some of the drugs available for a long-term supply. These drugs are marked as "FFQL" in our Drug Formulary.*

You won't pay more than $0 for tier 3 and $30 for tier 4 for a 2-month supply and $0 for tier 3 and $45 for tier 4 for a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count towards your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

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

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Go to our plan's Drug List or call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 7:

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

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

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

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

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

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

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

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

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

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

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

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

3. If you're retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

   You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

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

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

You must submit your Part C (medical services) claim to us within 365 days of the date you received the service, item, or Part B drug.

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

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

- You don't have to use the form, but it'll help us process the information faster. You will need to specify your name, your member ID number, your address, the date of service or fill and your provider.
- Download a copy of the form from our website (www.mcsclassicare.com) or call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) and ask for the form.

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

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

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

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

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

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

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

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

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English, including Spanish and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about the plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-866-627-8183 (Toll Free) (TTY users 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 can also file a

complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

Es requerido que su plan garantice que todos los servicios, tanto clínicos como no clínicos, se brinden de una manera culturalmente competente y sean accesibles para todos los afiliados, incluidos aquellos con dominio limitado del español, habilidades limitadas de lectura, discapacidad auditiva o aquellos con antecedentes culturales y étnicos diversos. Los ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, pero no se limitan a la disposición de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder a las preguntas de los miembros que no hablan español. También podemos brindarle información en otros idiomas, como inglés, braille, letra grande u otros formatos alternativos, sin costo alguno si lo necesita. Es requerido que le proporcionemos 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 Servicios para los miembros al 1-866-627-8183 (Libre de cargos). (Usuarios de TTY, llamen al 1-866-627-8182).

Es requerido que nuestro plan le brinde 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 de dentro de la red. Si se encuentra en una situación en la que no hay especialistas en nuestra red del plan que cubran un servicio que necesita, llame a nuestro plan para obtener información sobre dónde acudir para obtener este servicio con costos compartidos de 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 Servicios para los miembros al 1-866-627-8183 (libre de cargos), (Usuarios de TTY llamen al 1-866-627-8182); 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 you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions

or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL RESPONSIBILITY

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

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

PHI is information that can identify you (name, last name, social security number); including demographic information (like address, zip code), obtained from you through a request or other document in order to obtain a service, created and received by a health care provider, a medical plan, intermediaries who submit claims for medical services, business associates, and that is related to (1) your health, past, present, or future physical or mental conditions; (2) the provision of medical care to you, or (3) past, present, or future payments for the provision of such medical care. For purposes of this Notice, this information will be called PHI. This Notice of Privacy Practices has been written and amended to 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.

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 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 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)(c) of the Privacy Regulation.

Covered Entities

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

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.

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 way 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 adverse events involving food, supplements, products and product defects, among others.

Abuse or neglect

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

Legal proceedings

We may use or disclose your PHI during the course of any judicial or administrative proceedings: (1) in response to an order from a court or administrative agency (provided that the covered entity discloses only the PHI expressly specified by such order); or (2) in response to a subpoena, discovery request, or other lawful process.

Law enforcement officials

We may use or disclose your PHI to law enforcement officials. For example, we may provide information necessary to report a crime, or to locate or identify a suspect, a fugitive, material witness or missing person, or if 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: (1) to provide health care for the inmate; (2) to protect the health and safety of the inmate or other persons, or (3) 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, and other authorities, or heads of state.

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.

Substance Use Disorder Patient Records

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

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 to not treat this person as your authorized representative if, in our professional judgment, we 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 an 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 a group counseling session, 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 PHI for any other reason not described in this Notice.

Disclosures to the Secretary of Health and Human Services

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

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI

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. To access your information, contact Member Services to submit your request. We will validate your identity assisting you. You may also visit any of our Service Centers 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 systems is incomplete or incorrect, you may request that we amend it. You may 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 digital format.

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 based 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, so they can 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 Member Services. 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 Member Services, PO BOX 191720, San Juan, PR 00919-1720; for MCS Life 787-281-2800 (Metro Area), 1-888-758-1616 (toll free), 1-866-627-8182 (TTY users), for MCS Classicare 787-620-2530 (Metro Area), 1-866-627-8183 (toll free). Our service hours are Monday to Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. Our hours from April 1 to September 30 are Monday to Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 4:30 p.m. You can file a grievance in person or by mail. If you need help filing a grievance, Member Services 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.

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 https://reportfraud.ftc.gov/#/.

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
privacy@medicalcardsystem.com

EFFECTIVE DAY

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

Revisions:
02/2026

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

As a member of MCS Classicare RxMax (HMO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star Ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications and credentials of the providers and pharmacies in our network and how we pay the providers in our network.
  - Medical professionals must display in their offices their credentials (Licenses, Certificates, and Diplomas) and capabilities to allow patients to make informed choices about their health care.
  - All providers must display their Malpractice Coverage Certificate so that their patients can easily read it. The information is also available upon request. Contact the plan for details.
  - If a provider does not have the Malpractice Coverage Certificate, he or she must inform and display such information in a prominent location in his or her office.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

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

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

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

You have the right to give instructions about what is to be done if you can't make medical decisions for yourself

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-866-627-8183 (Toll Free). (TTY users call 1-866-627-8182).
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people**. Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

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 the desire or will regarding receiving of medical treatment. Pursuant to Puerto Rico law (Act. 160-2001). Every person interested in giving advance directives must prepare a statement complying with the following requirements:

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

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

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

If your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you 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 ask us to reconsider decisions we made

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.

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

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

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

If you believe you 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 from these places:

- **Call Member Services** at 1-866-627-8183 (Toll Free). (TTY users call 1-866-627-8182).
- **Call your local SHIP** at 1-877-725-4300 (Metro Area) 1-800-981-0056 (Mayagüez Area) 1-800-981-7735 (Ponce Area).
- **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

Get more information about your rights from these places:

- **Call our plan's Member Services at 1-866-627-8183 (Toll Free)**. (TTY users call 1-866-627-8182).
- **Call your local SHIP** at 1-877-725-4300 (Metro Area) 1-800-981-0056 (Mayagüez Area) 1-800-981-7735 (Ponce Area).
- Contact **Medicare**.

- Visit Medicare.gov to read the publication *Medicare Rights & Protections.* (available at: Medicare Rights & Protections)
- Call 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of the plan are listed below. For questions, call Member Services at 1-866-627-8183 (Toll Free). (TTY users call 1-866-627-8182).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show your plan membership card whenever you get medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you're responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.

  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.

- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:

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

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand

which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit Medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about

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

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

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

Making an appeal

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

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

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

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

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

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

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

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

- **Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.mcsclassicare.com.)
  - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.mcsclassicare.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

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

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). You can also get help or information from your SHIP.

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

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

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

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

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

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

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

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

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms:

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

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

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

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

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

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

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

- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. If they

take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only**. To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.

- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:

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

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

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

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in tier five (5) – specialty drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five (5) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
   - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
     - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
     - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
     - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
     - You can't ask us to change the cost-sharing tier for any drug in Tier 5 - Specialty Drugs.

- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally *won't* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal term:

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

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

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

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

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)

- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

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

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which are available on our website www.mcsclassicare.com. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Deadlines for a standard coverage decision about payment for a drug you have already bought

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

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

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

Section 6.5 How to make a Level 1 appeal

Legal Terms:

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

A fast appeal is called an **expedited redetermination.**

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request** or call us. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 1-866-627-8183 (Toll Free) (TTY 1-866-627-8182). Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Redetermination Request Form, which is available on our website https://mcsclassicare.com/SiteAssets/docs/ES/solicitud-redeterminacion-2024-es.pdf. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. **Section 6**.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. **Section 6**.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar** days after we get your request.

- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.6 How to make a Level 2 appeal

Legal Term:

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

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

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

For fast appeals:

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

For standard appeals:

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

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.). In this case, the independent review organization will send you a letter that:

- Explains the decision.

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

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

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

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. You can call State Health Insurance Assistance Program (SHIP: Programa Estatal de Asistencia Sobre Seguros de Salud) at 1-877-725-4300 (Metro Area), 1-800-981-0056 (Mayagüez Area) or 1-800-981-7735 (Ponce Area). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your

doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

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

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

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

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

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

Legal Term:

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. You can call State Health Insurance Assistance Program (SHIP: Programa Estatal de Asistencia Sobre Seguros de Salud) at 1-877-725-4300 (Metro Area), 1-800-981-0056 (Mayagüez Area) or 1-800-981-7735 (Ponce Area). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

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

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**

- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.

  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

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

Level 4 appeal

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

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

Level 5 appeal

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

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

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

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

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

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

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

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

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

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

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

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

- **Calling Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- 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 became the reason for the grievance 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 a coverage decision. You may also file an expedited grievance if we refuse to grant you a request for an expedited coverage decision or appeal. When you request an expedited grievance, we will provide you with a response within 24 hours. If you would like to file an expedited grievance you may call us.
  - Either you or your authorized representative may file a grievance. The person you name will act as your "representative." It may be a relative, a friend, a lawyer, a doctor, or any other person or provider you choose to act on your behalf. There may be someone who is already legally authorized to act as your authorized representative under State law. If you wish for someone in particular to act on your behalf, but that person has not yet been authorized by the Court or State law, call Member Services 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.

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

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

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

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

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

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

Or

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

Section 10.4 You can also tell Medicare about your complaint

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

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

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

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

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

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

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

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

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan, or
  - Original Medicare *without* a separate Medicare drug plan.
    - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

  Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

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

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

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

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

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

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan, or
- Original Medicare *without* a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will usually end** on the first day of the month after we get your request to change your plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

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

If you have questions about ending your membership you can:

- **Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182)**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from MCS Classicare RxMax (HMO) when your new plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from MCS Classicare RxMax (HMO) when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll**. Call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from MCS Classicare RxMax (HMO) when your coverage in Original Medicare starts.

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

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

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

SECTION 5 MCS Classicare RxMax (HMO) must end your plan membership in certain situations

MCS Classicare RxMax (HMO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area

- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182).

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

MCS Classicare RxMax (HMO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Member Services 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182). If you have a complaint, such as a problem with wheelchair access, Member Services 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 RxMax (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 Nondiscrimination Notice Under Section 1557 of the Affordable Care Act.

MCS Advantage, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability.

MCS Advantage, Inc.:

- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including:
  - Qualified interpreters for individuals with disabilities
  - Information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities;
- Provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the MCS Classicare Member Services at 1-866-627-8183 (toll free). Our hours of operations are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. From April 1 to September 30 are Monday through Friday 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 4:30 p.m. TTY users should call 1-866-627-8182.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age, or disability, our Section 1557 Coordinator is available to help you. You can file a grievance at any MCS Service Center conveniently located around the island, or by mail, fax, or email:

Mailing address:	MCS Advantage, Inc. Section 1557 Coordinator P.O. Box 195429 San Juan, PR 00919-5429
Telephone number:	1-866-627-8183 Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. From April 1 to September 30 are Monday through Friday, 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 4:30 p.m.

TTY number:	1-866-627-8182
Fax number:	787-620-7765
Email:	section1557coordinator@medicalcardsystem.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

This notice is available at our website: www.mcsclassicare.com.

SECTION 5 Protections When Reporting Suspicions on Fraud, Abuse and/or Waste

Protections When Reporting Suspicions on Fraud, Abuse and/or Waste ("Whistleblower Protections")

MCS complies with federal and state regulations establishing that any person and/or entity must report any suspicion of fraud, abuse and/or waste identified against Medicare and/or Medicaid Program. In complying with federal and state regulations, including False Claims Act, 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.

Examples of potential fraud, waste and/or abuse can be:

- Any service billed by a provider, hospital and/or facility to MCS that was not received.

- Someone uses your Medicare card to get medical care, prescriptions, supplies or equipment without your authorization.
- Someone bills for medical equipment after it has been returned and/or was not received by you.
- Pharmacy bills drugs not received by you.

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).

This confidential line allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that MCS will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is medicare.gov.

CHAPTER 12:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of MCS Classicare RxMax (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 our 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 haven't gotten 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the covered year.

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

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

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

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

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

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

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five (5) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug

coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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

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

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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 and prescription drugs don't count toward the maximum out-of-pocket amount.

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

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage

Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

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

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

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

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare** or **Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

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

Prescription Drug Benefit Manager or Pharmacy Benefit Manager (PBM) – It is a third party

administrator of prescription drugs programs. They are primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.

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

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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

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

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine

(non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

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

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

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

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

MCS Classicare RxMax (HMO) Member Services

Method	Member Services – Contact Information
Call	1-866-627-8183 Calls to this number are free. Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31 and 8:00 a.m. to 8:00 p.m. Monday through Friday and Saturday from 8:00 a.m. to 4:30 p.m. from April 1 to September 30. Member Services 1-866-627-8183 (Toll Free) (TTY users call 1-866-627-8182) 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. Member Services PO BOX 191720 San Juan, PR 00919-1720
Website	www.mcsclassicare.com

Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program)

Programa Estatal de Asistencia Sobre Seguros de Salud (SHIP: State Health Insurance Assistance Program) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
Call	1-877-725-4300 (San Juan Area) 1-800-981-0056 (Mayagüez Area) 1-800-981-7735 (Ponce Area)
TTY	787-919-7291 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.

Method	Contact Information
Write	State Health Insurance Assistance Program Puerto Rico Office of the Ombudsman for the Elderly P.O. Box 191179 San Juan, PR 00919-1179 shippr@oppea.pr.gov
Website	https://www.oppea.pr.gov

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*