



**2010 Summary of Benefits
Mercy Care Advantage (HMO) H5580**

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2010 Summary of Benefits

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Mercy Care Advantage (HMO). Our plan is offered by SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION/Mercy Care Advantage (HMO), a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call Mercy Care Advantage (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Mercy Care Advantage (HMO) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Mercy Care Advantage (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Mercy Care Advantage (HMO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Mercy Care Advantage (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers.

We also offer more benefits, which may change from year to year.

WHERE IS Mercy Care Advantage (HMO) AVAILABLE?

The service area for this plan includes: Maricopa, Pima, and Santa Cruz Counties, AZ. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN Mercy Care Advantage (HMO)?

You can join Mercy Care Advantage (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease generally are not eligible to enroll in Mercy Care Advantage (HMO) unless they are members of our organization and have been since their dialysis began.

You must also receive assistance from the state to join this plan.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

Mercy Care Advantage (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at <http://www.MercyCareAdvantage.com>. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Mercy Care Advantage (HMO) nor the Original Medicare Plan will pay for these services.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Mercy Care Advantage (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Mercy Care Advantage (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.MercyCareAdvantage.com/AdvantageDrug.html>. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Mercy Care Advantage (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members'

ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at

<http://www.MercyCareAdvantage.com/AdvantageDrug.html>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Mercy Care Advantage (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Health Services Advisory Group (HSAG) at (602) 264-6382.

As a member of Mercy Care Advantage (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Health Services Advisory Group (HSAG) at (602) 264-6382.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Mercy Care Advantage (HMO) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Mercy Care Advantage (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.

- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at (602) 263-3000 or (800) 624-3879 to obtain a copy of the plan ratings for this plan. TTY users call (866) 624-3879.

Please call Mercy Care Advantage (HMO) for more information about Mercy Care Advantage (HMO).

Visit us at www.MercyCareAdvantage.com or, call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
Open 24 Hours Mountain

Current members should call toll-free (800) 624-3879 for questions related to the Medicare Advantage Program.
(TTY/TDD (866) 602-1982)

Prospective members should call toll-free (866) 571-5781 for questions related to the Medicare Advantage program. (TTY/TDD (866) 602-1982)

Current members should call locally (602) 263-3000 for questions related to the Medicare Advantage program. (TTY/TDD (602) 248-9273)

Prospective members should call locally (602) 414-7630 for questions related to the Medicare Advantage program. (TTY/TDD (602) 248-9273)

Current members should call toll-free (800) 624-3879 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (866) 602-1982)

Prospective members should call toll-free (866) 571-5781 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (866) 602-1982)

Current members should call locally (602) 263-3000 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (602) 248-9273)

Prospective members should call locally (602) 414-7630 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (602) 248-9273)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Mercy Care Advantage (HMO) for details.

SECTION II - SUMMARY OF BENEFITS

Benefit	Original Medicare	Mercy Care Advantage (HMO)
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IMPORTANT INFORMATION

1 - Premium and Other Important Information	The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.	<p>General \$19.60 monthly plan premium in addition to your monthly Medicare Part B premium.*</p>
		*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.
	In 2010 the monthly Part B Premium is \$0 or \$ 110.50 and the yearly Part B deductible amount is \$0 or \$ 155.00	<p>In-Network In 2010 the yearly Part B deductible amount is \$0 or \$155.00.* Contact the plan for services that apply.</p>
	<p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2010, this amount is \$85,000 for singles, \$170,000 for married couples.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325- 0778.</p>	
2 - Doctor and Hospital Choice	You may go to any doctor, specialist or hospital that accepts Medicare.	<p>In-Network You must go to network doctors, specialists, and hospitals.</p>
(For more information, see		Referral required for network hospitals and specialists

Emergency - #15 and Urgently Needed Care - #16.)		(for certain benefits).
		You may have to pay a separate copay for certain doctor office visits.
SUMMARY OF BENEFITS		
INPATIENT CARE		
3 - Inpatient Hospital Care		In-Network In 2010 the amounts for each benefit period, \$0 or: Days 1 - 60: \$ 1,100 deductible* Days 61 - 90: \$275 per day* Days 91 - 150: \$ 550 per lifetime reserve day*
(includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period, \$0 or: Days 1 - 60: \$ 1,100 deductible* Days 61 - 90: \$275 per day* Days 91 - 150: \$550 per lifetime reserve day*	You will not be charged additional cost sharing for professional services.
	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	Plan covers 90 days each benefit period.
	Lifetime reserve days can only be used once.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
	A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	
4 - Inpatient	Same deductible and copay as	In-Network

Mental Health Care	inpatient hospital care (see "Inpatient Hospital Care" above).	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")
	190 day lifetime limit in a Psychiatric Hospital.	You get up to 190 days in a Psychiatric Hospital in a lifetime.
		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility		General Authorization rules may apply.
(in a Medicare-certified skilled nursing facility)	In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 - 20: \$0 or \$0 per day* Days 21 - 100: \$0 or \$ 137.50 per day*	In-Network In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: \$0 or: Days 1 - 20: \$ 0 per day* Days 21 - 100: \$ 137.50 per day*
	100 days for each benefit period.	You will not be charged additional cost sharing for professional services.
	A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	For non-Medicare-covered SNF stays: Days 1 - 20: \$ 0 per day Days 21 - 100: \$ 137.50 per day
		Plan covers up to 100 days each benefit period
		No prior hospital stay is required.
6 - Home Health Care	\$0 copay.	General Authorization rules may apply.
(includes medically necessary intermittent skilled nursing care, home health aide		In-Network \$0 copay for Medicare-covered home health visits.*

services, and rehabilitation services, etc.)		
7 - Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.	General You must get care from a Medicare-certified hospice.
	You must get care from a Medicare-certified hospice.	
OUTPATIENT CARE		
8 - Doctor Office Visits	0% or 20% coinsurance	General See "Physical Exams," for more information.
		Authorization rules may apply.
		In-Network 0% or 0% to 20% of the cost for each primary care doctor visit for Medicare-covered benefits.* 0% or 0% to 20% of the cost for each in-area, network urgent care Medicare-covered visit.*
		0% or 0% to 20% of the cost for each specialist visit for Medicare-covered benefits.*
9 - Chiropractic Services	Routine care not covered	General Authorization rules may apply.
	0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	In-Network 0% or 0% to 20% of the cost for each Medicare-covered visit.*
		0% of the cost for up to 12 routine visit(s) every year
		Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) I you get it from a chiropractor or other

		qualified providers.
10 - Podiatry Services	Routine care not covered.	General Authorization rules may apply.
	0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network 0% or 0% to 20% of the cost for each Medicare-covered visit.*
		0% of the cost for up to 1 routine visit(s) every three months
		Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	0% or 45% coinsurance for most outpatient mental health services.	General Authorization rules may apply.
		In-Network 0% or 50% of the cost for each Medicare-covered individual or group therapy visit.*
		0% or 20% of the cost for each Medicare-covered individual or group therapy visit with a psychiatrist.*
12 - Outpatient Substance Abuse Care	0% or 20% coinsurance	General Authorization rules may apply.
		In-Network 0% or 50% of the cost for Medicare-covered individual or group visits.*
13 - Outpatient Services/Surgery	0% or 20% coinsurance for the doctor	General Authorization rules may apply.
	0% or 20% of outpatient facility charges	In-Network 0% or 0% to 20% of the cost for each Medicare-covered ambulatory surgical center visit.*
		0% or 0% to 20% of the cost for each Medicare-covered outpatient hospital facility visit.*

14 - Ambulance Services	0% or 20% coinsurance	General Authorization rules may apply.
(medically necessary ambulance services)		In-Network 0% or 0% to 20% of the cost for Medicare-covered ambulance benefits*
15 - Emergency Care	0% or 20% coinsurance for the doctor	0% or 0% to 20% of the cost (up to \$50) for Medicare-covered emergency room visits.*
(You may go to any emergency room if you reasonably believe you need emergency care.)	0% or 20% of facility charge	Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.
	You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.	If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit.
	NOT covered outside the U.S. except under limited circumstances.	
16 - Urgently Needed Care	0% or 20% coinsurance	General 0% or 0% to 20% of the cost for Medicare-covered urgently needed care visits.*
(This is NOT emergency care, and in most cases, is out of the service area.)	NOT covered outside the U.S. except under limited circumstances.	
17 - Outpatient Rehabilitation Services	0% or 20% coinsurance	General Authorization rules may apply.
(Occupational Therapy, Physical Therapy, Speech and Language Therapy)		In-Network 0% or 0% to 20% of the cost for Medicare-covered Occupational Therapy visits.*

		0% or 0% to 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.*
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment	0% or 20% coinsurance	General Authorization rules may apply.
(includes wheelchairs, oxygen, etc.)		In-Network 0% or 0% to 20% of the cost for Medicare-covered items.*
19 - Prosthetic Devices	0% or 20% coinsurance	In-Network 0% or 0% to 20% of the cost for Medicare-covered items.*
(includes braces, artificial limbs and eyes, etc.)		
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies	0% or 20% coinsurance	In-Network 0% or 0% to 20% of the cost for Diabetes self-monitoring training.*
(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	0% or 0% to 20% of the cost for Nutrition Therapy for Diabetes.*
		0% or 0% to 20% of the cost for Diabetes supplies.*
21 - Diagnostic Tests, X-Rays, and Lab Services	0% or 20% coinsurance for diagnostic tests and x-rays	General Authorization rules may apply.
	\$0 copay for Medicare-covered lab services	In-Network \$0 copay for Medicare-covered:

	Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	- lab services
		- diagnostic procedures and tests
		0% or 0% to 20% of the cost for Medicare-covered X-rays.*
		0% or 0% to 20% of the cost for Medicare-covered diagnostic radiology services.*
		0% of the cost for Medicare-covered therapeutic radiology services.*
PREVENTIVE SERVICES		
22 - Bone Mass Measurement	0% or 20% coinsurance	General Authorization rules may apply.
(for people with Medicare who are at risk)	Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network 0% or 0% to 20% of the cost for Medicare-covered bone mass measurement.*
23 - Colorectal Screening Exams	0% or 20% coinsurance	In-Network 0% or 0% to 20% of the cost for Medicare-covered colorectal screenings.*
(for people with Medicare age 50 and older)	Covered when you are high risk or when you are age 50 and older.	
24 - Immunizations	\$0 copay for Flu and Pneumonia vaccines	In-Network \$0 copay for Flu and Pneumonia vaccines.
(Flu vaccine,	0% or 20% coinsurance for	\$0 copay for Hepatitis B vaccine.

Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	Hepatitis B vaccine	
	You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	No referral needed for Flu and pneumonia vaccines.
25 - Mammograms (Annual Screening)	0% or 20% coinsurance	
(for women with Medicare age 40 and older)	No referral needed.	In-Network 0% or 20% of the cost for Medicare-covered screening mammograms.*
	Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	
26 - Pap Smears and Pelvic Exams	\$0 copay for Pap smears	General Authorization rules may apply.
(for women with Medicare)	Covered once every 2 years. Covered once a year for women with Medicare at high risk.	In-Network 0% of the cost for Medicare-covered pap smears.*
	0% or 20% coinsurance for Pelvic Exams	0% or 20% of the cost for Medicare-covered pelvic exams.*
27 - Prostate Cancer Screening Exams	0% or 20% coinsurance for the digital rectal exam.	In-Network 0% or 20% of the cost for Medicare-covered prostate cancer screening.*
(for men with Medicare age 50 and older)	\$0 for the PSA test; 0% or 20% coinsurance for other related services.	
	Covered once a year for all men with Medicare over age 50.	

28 - End-Stage Renal Disease	0% or 20% coinsurance for renal dialysis	General Authorization rules may apply.
	0% or 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease	In-Network 0% or 20% of the cost for renal dialysis*
	Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	0% or 0% to 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.*
29 - Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part B General \$0 yearly deductible for Part B-covered drugs.*
		0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*
		Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.MercyCareAdvantage.com/AdvantageDrug.html on the web.
		Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).

		Your in-network prescription coverage may be limited to the plan's service area. This means that if you travel outside the service area, you may have to pay the full cost of your prescription. In certain emergencies, your drugs will be covered if you get them at an out-of-network-pharmacy although you may have to pay additional charges. Contact the plan for details.
		Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.
		The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
		Some drugs have quantity limits.
		Your provider must get prior authorization from Mercy Care Advantage (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.
		If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
		In-Network You pay a \$0 yearly deductible.
		Initial Coverage Depending on your income and institutional status, you pay the following:

		<p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> o A \$0 copay or o A \$1.10 copay or o A \$2.50 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> o A \$0 copay or o A \$3.30 copay or o A \$6.30 copay.
		<p>Retail Pharmacy You can get drugs the following way(s):</p>
		- one-month (31-day) supply
		- three-month (90-day) supply
		<p>Long Term Care Pharmacy You can get drugs the following way(s):</p>
		- one-month (31-day) supply
		<p>Mail Order You can get drugs the following way:</p>
		- three-month (90-day) supply
		<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 copay.</p>
		<p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Mercy Care Advantage (HMO).</p>
		You can get drugs the following way:
		- one-month (31-day) supply
		<p>Out-of-Network Initial Coverage Depending on your income and institutional status, you will be</p>

		<p>reimbursed by Mercy Care Advantage (HMO) up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> o A \$0 copay or o A \$1.10 copay or o A \$2.50 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> o A \$0 copay or o A \$3.30 copay or o A \$6.30 copay.
		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.</p>
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network \$0 copay for Medicare-covered dental benefits.* \$0 copay for the following preventive dental benefits:</p>
		- up to 1 oral exam(s) every six months
		- up to 1 cleaning(s) every six months
		- up to 1 fluoride treatment(s) every six months
		- up to 1 dental x-ray(s) every year
		<p>Plan offers additional comprehensive dental benefits</p> <p>\$100 limit for comprehensive dental benefits every year</p>
31 - Hearing Services	Routine hearing exams and hearing aids not covered.	<p>In-Network \$0 copay for hearing aids.</p>
	0% or 20% coinsurance for diagnostic hearing exams.	- 0% or 0% to 20% of the cost for Medicare-covered diagnostic hearing exams*

		\$1,200 limit for hearing aids every year.
32 - Vision Services	0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.	In-Network \$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery*
	Routine eye exams and glasses not covered.	- glasses
	Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	- contacts
	Annual glaucoma screenings covered for people at risk.	- 0% or 0% to 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*
		- 0% of the cost for up to 1 routine eye exam(s) every year
		\$175 limit for eye wear every year.
33 - Physical Exams	0% or 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage	In-Network \$0 copay for routine exams.
	When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	\$0 copay for Medicare-covered benefits.* Limited to 1 exam(s) every year.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	In-Network This plan covers the following health/wellness education benefits:
		- Written health education materials, including Newsletters
		- Nutritional Training

		-Nutritional benefit
		- Additional Smoking Cessation \$0 copay for each Medicare-covered smoking cessation counseling session.*
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.

SECTION III – MERCY CARE ADVANTAGE (HMO) (MEDICARE) AND MERCY CARE PLAN (AHCCCS/ALTCS)

Mercy Care Advantage (HMO) is a Medicare Advantage Prescription Drug Special Needs Plan with a Medicare contract. The plan is designed to serve Medicare beneficiaries who are also eligible for Medicaid (Arizona Health Care Cost Containment System (AHCCCS) benefits in Maricopa, Pima and Santa Cruz counties, Arizona. If you have Arizona Long Term Care System (ALTCS) services, you may receive additional benefits under this plan after the exhaustion of Medicare-covered benefits.

If you are a current Mercy Care Plan AHCCCS/ALTCS member, and choose Mercy Care Advantage (HMO), you may receive both your Medicare and Medicaid benefits and your Part D prescription drugs from one company – Southwest Catholic Health Network. If you enroll in Mercy Care Advantage (HMO) for your Medicare benefits and remain enrolled in another Medicaid health plan, your Medicaid benefits will be provided by that plan.

The cost sharing amounts you will pay for Mercy Care Advantage (HMO) benefits are listed in Section 2.

Services with Special Circumstances

A. Inpatient Mental Health Care

Once 190 days of Medicare covered inpatient behavioral health benefits in a Medicare certified psychiatric hospital are used, Mercy Care Plan Arizona Long Term Care System (ALTCS) members will receive behavioral health services through Mercy Care Plan providers. If you have coverage through another AHCCCS ALTCS plan, you will need to get inpatient psychiatric hospital services through that plan.

All other Mercy Care Advantage (HMO) members (AHCCCS members not on ALTCS) will receive Medicaid behavioral health services through their Regional Behavioral Health Authority (RBHA) once the 190-day Medicare lifetime limit has been reached. While on AHCCCS, there is no limit on the number of covered days in a psychiatric hospital. The 190-day limit may not count if you are receiving mental health services in a psychiatric ward of an acute care hospital.

See Section 2 for additional information about Inpatient Mental Health Care services.

B. Skilled Nursing Facility

While on the ALTCS program, there is no limit on the number of covered Medicaid days in a Skilled Nursing Facility. If you are not enrolled in ALTCS, there is a 90-day limit after the exhaustion of the 100 Medicare covered days.

See Section 2 for additional information about Skilled Nursing Facility services.

C. Outpatient Mental Health Care/Outpatient Substance Abuse Care

Coinsurance amounts for Mercy Care Advantage (HMO) outpatient mental health and substance abuse services are paid by Mercy Care Plan for Mercy Care Plan ALTCS members. Coinsurance amounts for other ALTCS members will be paid by their ALTCS plan.

Coinsurance amounts will be paid by the RHBA for all other eligible members. You pay \$0.

See Section 2 for additional information about Outpatient Mental Health Care/Outpatient Substance Abuse Care.

SECTION IV MEDICAID BENEFITS PROVIDED BY MERCY CARE PLAN

SERVICES COVERED BY MEDICAID (AHCCCS) THAT ARE NOT COVERED BY MEDICARE

Medicaid services are provided through the Arizona Health Care Cost Containment System (AHCCCS) program. Mercy Care Plan is one of the contracted AHCCCS health plans to offer the following services. If you are enrolled in a Medicaid (AHCCCS) plan other than Mercy Care Plan, you will need to get your Medicaid services from your other Medicaid (AHCCCS) plan.

Benefit	Medicaid	Mercy Care Plan
<p>Transportation (Routine)</p> <p>Non-emergency medically necessary transportation to and from Medicaid-eligible medical services.</p>	<p>\$0 copay</p>	<p>In-Network \$0 copay</p> <p>If you are not enrolled in Mercy Care Plan for your Medicaid (AHCCCS) benefits, you will need to get your transportation services from your Medicaid (AHCCCS) plan.</p>
<p>Interpreter services</p> <p>Interpreter services are available to help you get services. Oral interpretation is available for any language.</p> <ul style="list-style-type: none"> • Spoken language interpreter services. • Hearing interpreter services. 	<p>\$0 copay</p>	<p>In-Network \$0 copay</p>
<p>Non-Skilled Nursing Home Care</p> <p>Medicaid (AHCCCS) members not enrolled in the ALTCS program have a 90-day maximum benefit.</p>	<p>\$0 copay</p>	<p>\$0 copay</p> <p>If you are not enrolled in Mercy Care Plan for your Medicaid (AHCCCS) benefits, you will need to get your non-skilled nursing home care from your Medicaid (AHCCCS) plan.</p>

LONG TERM CARE SERVICES COVERED BY MEDICAID THAT ARE NOT COVERED BY MEDICARE

Long term care services are provided through the Arizona Long Term Care System (ALTCS) program. Mercy Care Plan is one of the ALTCS health plans in Maricopa County contracted to offer the following services. If you are not enrolled in Mercy Care Plan for Medicaid (ALTCS) services, you will need to get your long term care services from your Medicaid (ALTCS) plan

Benefit	Medicaid	Mercy Care Plan
<p>Skilled nursing home care after the 100-day Medicare limit is exhausted</p>	<p>If you live in a nursing home, ALTCS will decide what your share of cost will be based on your income and certain expenses. They will send you a notice telling you the amount.</p> <p>If you live in a nursing home, ALTCS will decide what your share of cost will be based on your income and certain expenses. They will send you a notice telling you the amount. The nursing home will collect your share of cost from you every month.</p>	<p>Mercy Care Plan will assign a case manager</p>
<p>Alternative residential settings (in lieu of a nursing facility)</p> <ul style="list-style-type: none"> • Adult Foster Care • Therapeutic Home Care • Assisted Living Home • Assisted Living Center • Alzheimer’s Treatment Assistive Living Facility • Behavioral Health Level II and III • Therapeutic Home Care 	<p>If you live in an alternative residential setting or assisted living facility, you may have to share the cost, but it is called “room and board”.</p> <p>If you live in an alternative residential setting, such as an Adult Foster Care Home, Assisted Living Home, or an Assisted Living Center, you are required to pay for your room and board. Your room and board cost will be based on your income and certain expenses. Your case manager will let you know what you need to pay.</p>	<p>Mercy Care Plan will assign a case manager</p>

<p>Home and community based services (in lieu of a nursing facility):</p> <ul style="list-style-type: none"> • Adult Day Health Care • Attendant Care Services • Emergency Alert System • Habilitation • Home Delivered Meals. • Home Health Service (that do not meet Medicare certification guidelines) • Homemaker • Home Modification • Hospice Care • Personal Care • Private Duty Nursing • Respite • Self-Directed Attendant • Spouse Attendant Care 	<p>\$0 copay</p>	<p>\$0 copay</p>
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Cost Sharing Protections

AHCCCS pays your Medicare Part B premium of \$[XX.XX] each month and the federal government pays the \$[XX.XX] Medicare Part D monthly premium on your behalf because you automatically qualify for extra help for prescription drugs.

Cost sharing amounts (copayments and coinsurance) for 2010 will depend on the level of your Medicaid eligibility. Please contact Mercy Care Advantage (HMO) or your AHCCCS eligibility office for information about your level of Medicaid eligibility.

Mercy Care Advantage (HMO) will pay for your services first, unless you have other primary coverage (e.g. employer group plan). Your Medicaid plan is responsible for sharing in the cost for AHCCCS covered services and for certain Medicare services not covered by AHCCCS, like chiropractic. Mercy Care Plan will pay your coinsurance, deductible or copayment amounts listed in Section 2. You will only need to pay the designated copay for prescription drugs.